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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
Volume 155, No. 1 January 1979

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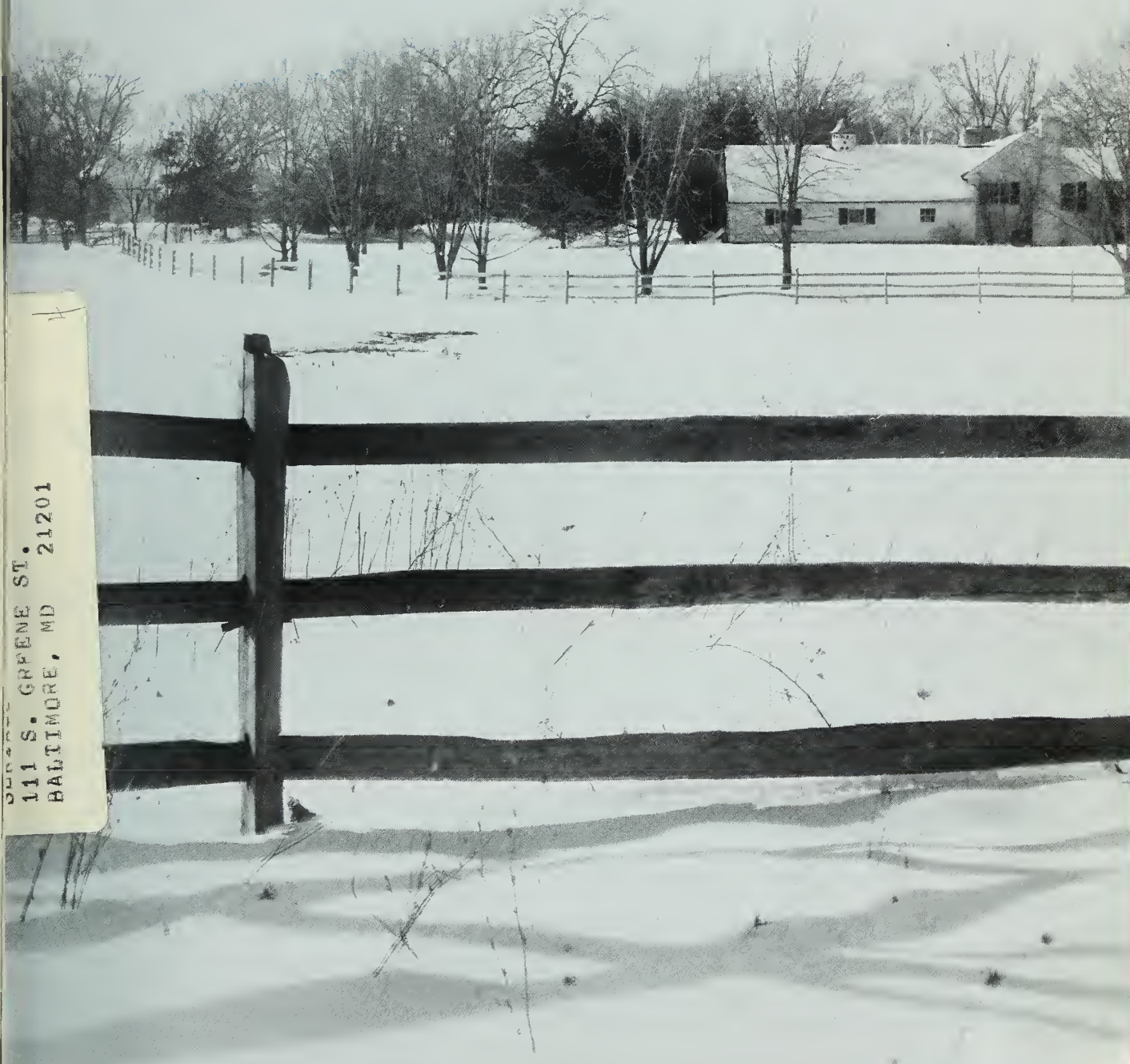
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Illinois Medical Journal

JANUARY, 1979

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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.



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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should period-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage or standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, blurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Editorials



Join the Voluntary Effort

Preliminary data released by members of the Illinois Voluntary Effort To Control Health Care Costs (VE) indicate that the cost of hospital care has been contained.

Average monthly hospital expenses increased by an average of 14.7% in 1977 over figures reported for each month in 1976.

It appears that the rate of Illinois hospital expenditures increase may be held to 11% this year, two percent lower than reductions initially targeted. This prediction was based on data gathered by the Illinois State Cost Containment Committee, (ISCCC) a joint ISMS-Illinois Hospital Association group charged with implementing the VE in Illinois. The state's VE target was to hold the rate of increase at 13% this year, 1.7% below the 1977 rate. Nationwide, the VE—directed by AMA, American Hospital Association and the Federation of American Hospitals—is also bettering targeted reductions.

Now, the VE has called upon ISMS members to bring 100% active support to their work. The cost of this support? Your time and energy. The means? Patient education.

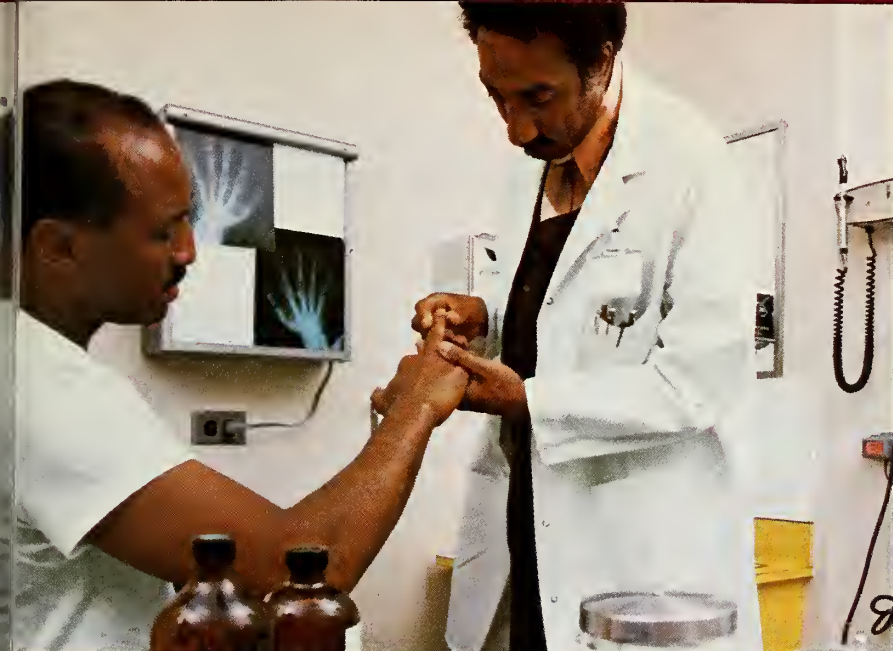
Later this month, ISMS will send each member a copy of an AMA brochure, "Physicians Cost Containment Checklist," and information on material for patient education. Local county medical societies will make available further information on "VE Week," proclaimed by Ill. Gov. James R. Thompson.

At the outset, physicians are asked to impress these four guidelines upon their patients:

- don't use the emergency room unless absolutely necessary.
- discuss the cost of medical procedures with your doctor
- don't ask your doctor for unnecessary tests
- encourage your employer to provide medical benefits that emphasize outpatient care.

Also this month, former ISMS President J.M. Ingalls, M.D., assumed chairmanship of the Illinois State Cost Containment Committee, which implements the Illinois Voluntary Effort. Dr. Ingalls, whose work in cost containment is well documented, has been chairman of the ISMS Task Force on Cost Effectiveness from inception in 1977.

ISMS has joined the Illinois Hospital Association and Chicago Hospital Council in a voluntary effort to demonstrate that cost containment is best implemented in the private sector. Data presented in this report have proven that point. Learn what you can do. Join the Voluntary Effort. Contact your county medical society today. ◀



Motrin⁴⁰⁰ TABLETS

ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn

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J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin⁴⁰⁰mg TABLETS

ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)

Bottles of 60

Bottles of 500

NDC 0009-0733-01

NDC 0009-0733-02

Motrin Tablets, 400 mg (orange)

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Unit of Use bottles of 120

NDC 0009-0750-01

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NDC 0009-0750-06

NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

Obituaries

Eide, Iver O., Antioch, died November 25, 1978, at the age of 83.

***Fahey, John J.,** Skokie, died December 4, 1978, at the age of 72. He was a 1931 graduate of Ohio State University. Dr. Fahey was former chief of staff at St. Francis Hospital, Evanston. He also taught orthopaedic surgery at Northwestern University.

****Fogelson, Samuel J.,** Chicago, died November 11, 1978, at the age of 81. He was a 1922 graduate of Rush Medical College. Dr. Fogelson was on the staffs of Northwestern Memorial and Cook County Hospitals. He also taught postgraduate medicine at Northwestern University and Cook County Hospital.

Grier, James Parks, Evanston, died November 8, 1978, at the age of 81. Dr. Grier was formerly on the staff of Evanston Community Hospital.

Lederer, Ludwig George, Chicago, died November 10, 1978, at the age of 66. Dr. Lederer was medical director of American Airlines. He graduated from the University of Illinois Medical School and later taught at Northwestern University and George Washington Medical School.

***Lofdahl, George A.,** Joliet, died December 15, 1978 at the age of 74. Dr. Lofdahl was a 1924 graduate of Loyola University Stritch School of Medicine.

***McMahan, Ernest Graham,** Mokena, died December 8, 1978, at the age of 86. He was a 1921 graduate of Loyola University Stritch School of Medicine.

***Morrison, George R.,** Belleville, died September 29, 1978, at the age of 53. He was a 1954 graduate of the University of Rochester.

****Rothbart, Fritz R.,** Chicago, died December 1, 1978, at the age of 79. Dr. Rothbart was a 1923 graduate of the University of Berlin, Germany. He was the former director of radiology and nuclear medicine at Thorek Hospital and Medical Center.

****Smiley, William A.,** Chicago, died October 11, 1978, at the age of 85. He was a 1922 graduate of Rush Medical College.

***Strassman, Bernard,** New Athens, died August 16, 1978, at the age of 61. Dr. Strassman was a 1939 graduate of the University of Illinois School of Medicine.

***Utz, Walter J.,** Peru, died October 8, 1978, at the age of 68. He was a 1936 graduate of Northwestern Medical School.

****Weinfeld, Gustave Frankel,** Highland Park, died June 4, 1978, at the age of 78. He was a 1924 graduate of the Michigan University Medical School.

***Wester, Edward A.,** Mt. Sterling, died November 1, 1978, at the age of 75. He was a 1930 graduate of Chicago Medical College.

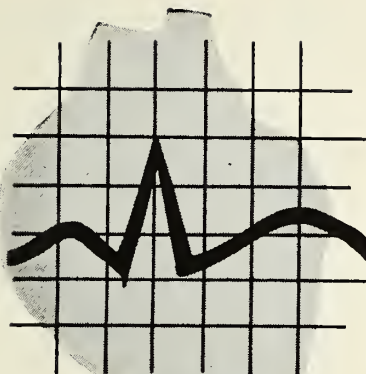
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**Indicates member of the ISMS Fifty Year Club.

NIM-3

Upjohn

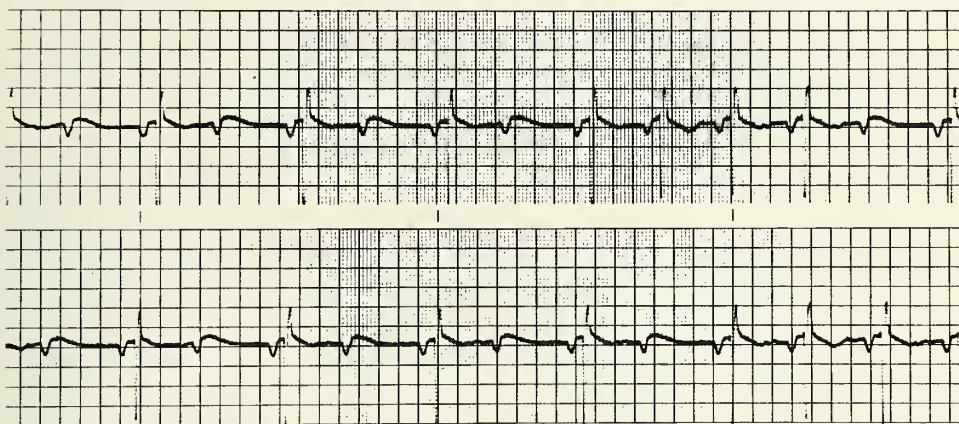
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ekg of the month

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JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This sixty-eight year old woman came to her physician because of symptoms of lightheadedness. She had never lost consciousness. She was always relieved of her lightheadedness if she lay down during an episode. Her physical examination was normal, excepting an irregular pulse. She was admitted to hospital and placed on telemetry. No symptoms occurred during these recordings, which were taken while the patient was supine.



Questions

1. The ECG rhythm strip shows:
 - A. Typical atrioventricular (AV) type I Wenckebach block.
 - B. Typical atrioventricular (AV) type II block.
 - C. Sinus rhythm with frequent blocked premature atrial beats.
 - D. Complete atrioventricular dissociation.
 - E. Evidence for classic digitalis intoxication.
2. Treatment for this patient would include:
 - A. Digoxin 0.25 mg. per day.
 - B. Quinidine sulfate 200 mg. four times per day.
 - C. A permanent demand pacemaker.
 - D. Prolonged periods of bedrest.
 - E. None of the above.

(Continued on page 39)

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, a new Illinois state law makes it more difficult to exercise this right. Unless you sign your prescriptions on the bottom line of your new prescription pads, the pharmacist is permitted to substitute another drug for your brand-name prescription.

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Pfizer PHARMACEUTICALS



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Richard Marson, M.D., a clinical Assistant Professor of Radiology at the Loyola University Medical Center.

This 41 year old male presented with 2 days of rectal bleeding. He had had abdominal surgery one month earlier for bowel obstruction with resection of infarcted small bowel. The patient had a past history of pancreatitis. There was no evidence of an upper GI bleed.

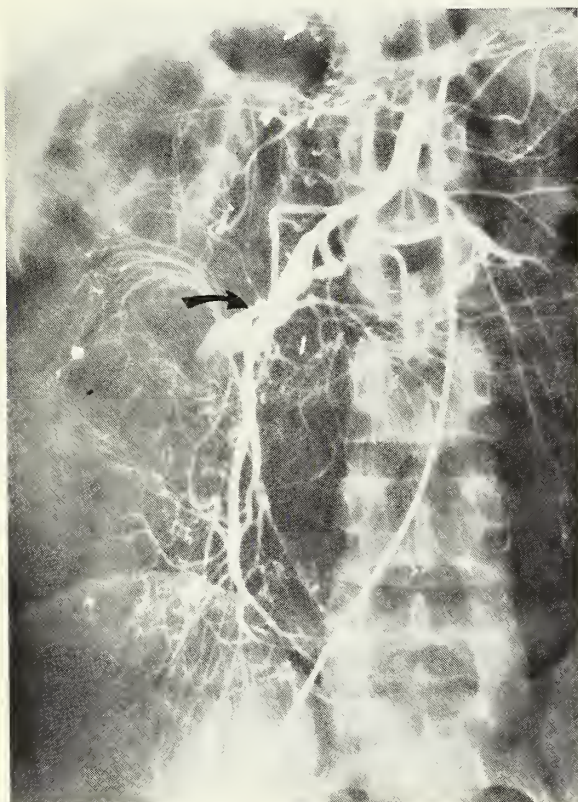


Figure 1

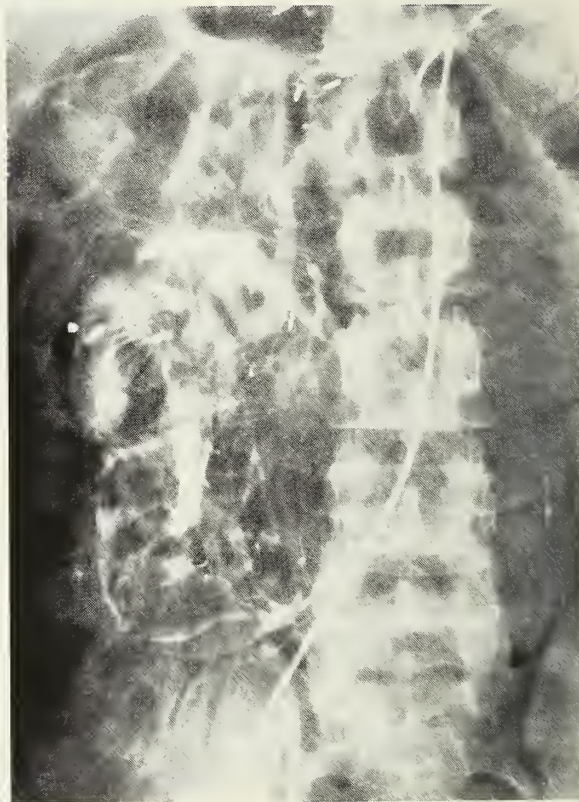


Figure 2

What's Your Diagnosis?

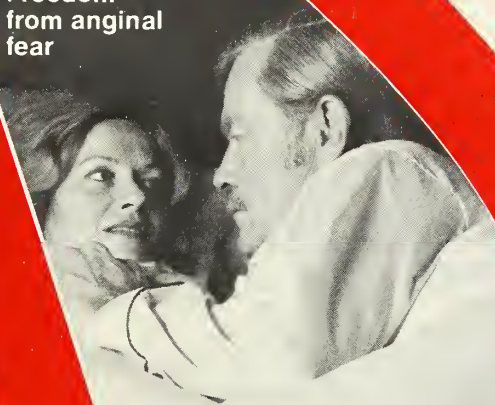
- A. Diverticular hemorrhage
- B. A-V Malformation
- C. Vascular Ectasia
- D. Arterio-Enteric Fistula

(Continued on page 27)

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fear



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PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

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2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

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Black Lung Benefits Reform Act of 1977

Information with respect to recent reforms in the Black Lung Benefits Program (Federal Coal Mine Health and Safety Act, Title IV, 1969) has been forwarded to IMJ by Ill. Rep. Paul Findley. Congressman Findley has encouraged physician education about these changes.

The 1977 Black Lung Benefits Reform Act promulgated under the aegis of the U.S. Dept. of Labor Employment Standards Administration, removed certain benefit eligibility restrictions. These changes may affect previously denied claims, and claims currently limited to social security payments. In summary, pertinent changes in the law provide that:

(1) More patients will be eligible to receive black lung benefits.

(2) Coal mine operators will assume a greater portion of costs.

(3) All previously denied claims to the Dept. of Labor are being reviewed. New claims are not necessary, and those newly approved will be reimbursed retroactively up to January, 1974.

(4) Claimants previously denied by the Social Security Administration may request either a second review or a referral of their file to the Dept. of Labor. Negative determinations will carry opportunity to present additional medical evidence.

(5) The definition of pneumoconiosis disability has been expanded, as has the definition of total disability.

(6) Provisions for dependent survivors have been extended, as have pertinent time limitations for filing required evidence.

(7) Chest X-rays and evidence of pulmonary or respiratory impairment will now be accepted as sufficient evidence of total disability.

Eligible beneficiaries include present and former coal miners and certain other workers exposed to coal dust, and surviving dependents. Pertinent disabilities include pneumoconiosis (black lung) and respiratory or pulmonary ailments resulting from employment in or around U.S. coal mines.

A claim for benefits must be filed within three years of medical determination of total disability or three years after enactment of the 1977 amendment. The benefits apply only to total disability.

Total disability is generally defined as inability to do regular work in or around a mine or coal preparation facility due to breathing impairment caused by pneumoconiosis.

Persons suffering from pneumoconiosis should be instructed to contact the nearest Social Se-

curity Administration office to obtain U.S. Dept. of Labor forms. After receiving these forms, the Department of Labor will return forms authorizing medical examination, which will be reimbursed through the Department.

The Department will recommend a physician to complete the medical examination. If the patient chooses another physician, he must first receive their authorization to qualify for reimbursement.

In addition to a monthly stipend, benefits include medical treatment for pneumoconiosis or heart conditions caused thereby. Treating physicians are those approved by the U. S. Dept. of Labor who have agreed to provide these services.

For further information, patients should be instructed to write: Division of Coal Mine Worker's Compensation, U.S. Department of Labor, Washington, D.C., 20210. ◀

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1,750	6,174.08	27,895.35	89,977.60	228,144.18
7,500	26,460.35	119,551.50	385,618.29	977,760.78

* Minimum initial deposit \$1.00 for Keogh and Individual Retirement accounts. (The Northern Trust offers a variety of savings plans with a minimum initial deposit of \$1.00.) Federal regulations require that money withdrawn before maturity earns regular passbook rate less 3 months' interest. There is no interest penalty for early withdrawal prior to age 59½ because of disability or for early withdrawal after 59½. Internal Revenue Service Regulations also provide for tax penalties for withdrawal prior to 59½ except in the case of death or disability.

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ISMS Takes Stand on National Health Insurance

ISMS recently waged its battle against national health insurance on two fronts, denouncing NHI at Sen. Kennedy's hearing in Chicago and at the AMA House of Delegates meeting.

ISMS borrowed a page from Sen. Kennedy's strategy book for testimony before his Human Resources Subcommittee on Health hearing in November.

Instead of testifying as scheduled, ISMS surrendered its place on the agenda to Montreal neurologist Raymond Robillard, M.D., an outspoken critic of Canada's NHI system and president of the Federation of Medical Specialists of Quebec. The move was designed to blunt testimony of Sen. Kennedy's hand-picked Canadian patients who—compared to carefully-selected Illinois patients—avoided financial hardship despite catastrophic illness.

ISMS President David S. Fox, M.D., set the stage for Dr. Robillard—who appeared at ISMS' request—by noting: "The Canadian NHI system has been hailed during previous hearings as a model for NHI in this country. Highlighting a few examples of the Canadian system's success while ignoring its deficiencies is deception." Dr. Robillard then proceeded to document the shortcomings, focusing upon cutbacks in medical education and research, deterioration of quality and rationing of health services.

"Since Medicare was enacted in Canada, we have fallen badly behind in quality, in education, and in research," Dr. Robillard told the hearing officers. "We cannot equal your brand of medicine, but you may do it for us if you copy our system. You can bring American medicine down to our level."

Explaining this statement, Dr. Robillard continued, "Canadian care may be 'free,' but it is strictly rationed by tight provincial budgets and rampant inflation. It is criminal to do certain neurological procedures without CAT scanners, yet in Quebec we cannot afford CAT scanners."

ISMS Written Testimony

ISMS' written statement, distributed to the subcommittee, attacked NHI as impractical and inflationary. It pointed out that more health care cannot be equated with better health, and defined NHI as another governmental effort to treat symptoms rather than causes. Poverty, lifestyle traits and environmental factors, it said, affect the nation's health, but NHI attacks none of these.

The report admitted to shortcomings in our present system, which include continuing acceleration of costs and inadequate protection against catastrophic illness costs. Still, the Consumer Price Index for the first six months of

1978 demonstrated that the cost of medical care services increased at a rate of 8.1% while the annualized inflation for all products stood at 8.3%.

Cost factors cited included the rising average age of the American population, expansion of services to previously unserved and underserved segments of the population, hospital employee salaries (which have nearly doubled since 1974) and the technological explosion in medicine.

The report clearly documented successful efforts in the private sector to contain health care costs. The Voluntary Effort had reduced the annualized rate of increase to 12.9%, and the Illinois Voluntary Effort contained that figure at 11.5%. Hospital activities, including shared services programs and such health planning activities as prospective rate review legislation were cited.

Finally, ISMS' statement quoted HEW figures showing that 81% of the population has adequate health insurance. The remaining 19% could be covered through private insurance and extended government programs already in existence. Catastrophic insurance, which already covers 60% of the population, the report noted, is readily obtained. The proposed solution: a concerted public education program, and addition of optional catastrophic coverage to basic health insurance policies.

The Results

ISMS' action dampened Sen. Kennedy's headline-grabbing plans. The media recounted Dr. Robillard's testimony . . . and a searing *Chicago Tribune* editorial labeled the hearing "Ted Kennedy's soap opera." Sen. Kennedy received another unexpected blow when Rep. James Corman (D-Calif.)—his former co-sponsor of a highly publicized NHI bill—labeled the senator's latest proposal as "totally unworkable."

At the AMA House of Delegates meeting, Ill. delegates unanimously supported the move which blocked AMA submission to Congress of a comprehensive NHI bill. The House authorized the AMA Board only to introduce, *if necessary*, a limited-scope bill aimed at covering the uninsured and providing catastrophic coverage. In reference committee testimony, Dr. Fox—representing the Ill. delegation—strongly opposed introduction of the AMA leadership's bill and argued that the proposal would hand NHI backers a golden opportunity. "What would our position be if Sen. Kennedy embraced the AMA proposal?" Dr. Fox asked. "We would be incapable of opposing a bill which could be touted as the creature of the medical profession." ◀

An Opinion

Duties and Powers of the Coroner's Office

In response to an inquiry from a states' attorney, the Illinois Attorney General recently rendered the following opinion. It may be of interest to physicians, particularly radiologists or pathologists.

FILE NO. S-1368

OFFICERS:

Powers of Coroner

I have your letter asking for my opinion as to whether a hospital may refuse a coroner's request that X-rays and other tests be made, when that request comes directly from the coroner, and not the coroner's physician. You also ask whether the coroner may transport the body, along with the test results, to the coroner's physician.

The office of coroner is provided for in "An ACT to revise the law in relation to coroners." (Ill. Rev. Stat. 1977, ch. 31, par. 1 *et seq.*) Under section 10 of the Act (Ill. Rev. Stat. 1977, ch. 31, par. 10) every coroner is required, under certain circumstances, to make a preliminary investigation into the circumstances of death. The section provides that:

* * *

"(e) Coroners in their discretion shall notify such physician as is designated in accordance with Section 10.1 to attempt to ascertain the cause of death, either by autopsy or otherwise."

* * *

Section 10.1 of the Act (Ill. Rev. Stat. 1977, ch. 31, par. 10.1) provides:

"Any medical examination or autopsy conducted pursuant to this Act shall be performed by a physician duly licensed to practice medicine in all of its branches, and wherever possible by one having special training in pathology. In Class I counties, such medical examinations or autopsies shall be performed by physicians appointed or designated by the coroner, and in Class II counties by physicians appointed or designated by the director of the Department of Public Health, upon the recommendation of the advisory board on necropsy service to coroners, after the board shall have consulted with the elected coroner."

* * *

The Act does not give the coroner the power to conduct medical examinations. All medical examinations must be conducted by the physician designated under section 10.1. When the coroner wants a medical examination performed, he must notify the designated physician who must then perform the necessary medical procedures.

Since a coroner does not have the authority to order medical examinations from anyone other than the physician designated under section 10.1, it is my opinion that any such order to a physician who is not so designated would be in excess of his authority. A hospital, therefore, may refuse such an order.

You have also expressed a concern about your coroner's practice of transporting the body to the physician designated in section 10.1 for the purpose of performing an autopsy. Under section 10.2 of the Act (Ill. Rev. Stat. 1977, ch. 31, par. 10.2) it is the duty and responsibility of the coroner, under certain circumstances, to cause an autopsy to be performed. Grants of power to officials are taken to include the power to carry out the duties imposed by the statute. (*Will County v. Woodhill Enterprises, Inc.* (1971), 4 Ill. App. 3d 68.) Therefore, the duty to cause an autopsy to be performed must carry with it a concomitant power to cause the body to be moved to a place where the autopsy may be performed.

In sum, a coroner is not authorized by law to order X-rays or any other medical procedure from anyone other than the physician designated in section 10.1. A hospital may refuse such an order. The duty to cause an autopsy to be performed, carries with it a concomitant power to cause the body to be moved to a place where the autopsy may be performed.

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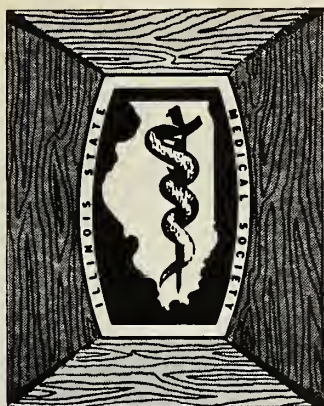
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Illinois Medical Journal

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Twenty-third Case in the Literature

Intussusception Associated With Intestinal Intubation

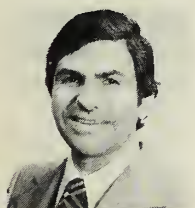
By DAVID SIMONOWITZ, M.D. AND DANIEL PALOYAN, M.D., F.A.C.S./WASHINGTON
STATE AND GLENVIEW, IL.

Non-operative decompression of the small bowel in patients with partial mechanical small bowel obstruction may in many instances be accomplished by intestinal intubation. Although the use of long tubes for this purpose is not usually associated with morbidity, occasional complications may result, including intestinal obstruction from the balloon, intestinal erosions or perforation, and knotting of the tube.¹

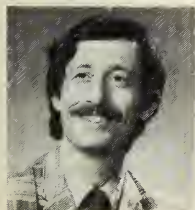
An infrequent but well-documented complication of the use of long intestinal tubes is intussusception either with the tube in place, or following its removal. We have recently treated three patients with intussusception associated with intestinal intubation. Our experience with these patients, and a review of the subject is presented.

Case Reports

Patient 1. A sixty-five-year-old white male with a 32 year history of Crohn's disease presented with nausea, vomiting, and crampy abdominal



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pain. He had undergone numerous operations for recurrent disease, and at his previous operation, a jejunocolic anastomosis had been performed. He was treated with parenteral corticosteroids, intravenous support, and finally a cantor tube was passed on the fifth hospital day. A small bowel contrast study through the tube documented obstruction at the jejunocolic anastomosis, due to recurrent disease. Six days later, he underwent a limited bowel resection and a new jejunocolic anastomosis was performed. The cantor tube, which had been left in place during the procedure, was removed eight days postoperatively. It had been taped to the patient's nose prior to its removal. One day following removal of the tube, the patient again developed signs and symptoms of small bowel obstruction. A barium enema examination was done and was diagnostic of an intussusception. Laparotomy was performed and a one foot long

antegrade jejuno-jejunal intussusception (Figure 1) was found. The intussusception was reduced and a three cm segment of jejunum was resected. This segment of bowel may have possibly been in contact with the cantor tube bag and no other abnormality was found to explain the intussusception. The patient made an uneventful recovery.

Patient 2. A 61 year old woman presented with signs and symptoms of a small bowel obstruction. She had previously received radiation therapy for carcinoma of the cervix, and had radiation enteritis and malabsorption. A cantor tube was passed and the patient was managed conservatively. She failed to improve and surgery was scheduled seven days later. A strictured segment of ileum was resected and primary ileo-ileal anastomosis performed. The cantor tube was left in place and over the next 23 days the patient, unable to aliment orally, required parenteral hyperalimentation. At re-operation a jejuno-jejunal antegrade intussusception was found with the mercury bag of the cantor tube as the lead point. This was reduced and the tube removed. This tube had not been fixed to the nose. The patient made an uneventful recovery but still has malabsorption associated with radiation enteritis.

Patient 3. This 18-year-old white female had been treated at this hospital for two years for chronic pancreatitis. She had undergone a previous vagotomy and pyloroplasty. Six months later she underwent a cholecystectomy and distal pancreatectomy. A prolonged and difficult post-operative course followed culminating in a completion pancreatectomy for chronic pancreatitis. This patient was treated one year later for a partial small bowel obstruction by passage of a cantor tube. During the next three days her symptoms became worse and an oral swallow of barium around the tube demonstrated a high jejuno-jejunal intussusception. The cantor tube had been taped to her nose, but was removed. She underwent a laparotomy six hours following removal of the tube, but no abnormalities were found. It is presumed that the intussusception reduced spontaneously after removal of the tube.

Discussion

Although intussusception following the use of long intestinal tubes is rare,² it may be a lethal complication if the diagnosis is delayed. However, if appropriate and timely surgical management is applied, the outcome is usually successful. Harris reported the first patient with intus-



Figure 1
An intraoperative photograph of an intussuscepted segment of jejunum. The arrows point to the site of intussusception.

susception following intubation of the small intestine in 1945³ and in our review of the English literature as of January 1977, only 22 patients had been reported.¹⁻¹³

In the 25 total reported patients (including the three patients presented here) there were five deaths, emphasizing the potentially lethal outcome of this condition. Twenty-two of these 25 patients were operated upon for the intussusception. In two patients the tube was removed with no operation performed,^{8,10} and one of these two patients expired. In another patient reported,³ the treatment was not described and the patient expired. Of eight patients undergoing a resection, two died. Thirteen patients underwent operative reduction of the intussusception without resection, resulting in one operative death. One patient underwent laparotomy after the tube had been removed and no intussusception was found although the intussusception was diagnosed on roentenographic examination.

These 25 patients ranged in age from 18 to 83 years, with a mean age of 51. A double-lumen tube was implicated in 11 patients and a single-lumen tube in eight. The type of intussusception was jejuno-jejunal in 13, ileo-ileal in nine, colocolonic in one, and unknown in two. Antegrade intussusception was noted in 12 patients, retrograde in eight, and the status of the intussusception was unknown in the remainder.

There appear to be at least two probable mechanisms of intussusception. The balloon bag itself may act as a lead point of an intussusception either in its passage through the bowel or during removal of the tube. McGoon¹¹ suggests an alternative explanation for intussusception,

citing frequent plications of the bowel around the tube which exist during and after the tube's removal. He suggests that the plications might act as a lead point for an intussusception. This hypothesis is supported by the finding that in some patients with proven intussusception, contrast studies performed pre-operatively through the tube failed to demonstrate the intussusception because the end of the tube was distal to the intussusception.⁶

"Currant jelly" stools and rectal bleeding as seen in pediatric patients with intussusception has not been reported in any of these patients. We concur with previous authors in noting that possibly the incidence of intussusception associated with a long intestinal tube could be reduced by observing certain precautions. Retrograde intussusception might be prevented by a staged, gradual withdrawal of the tube while it is disconnected from suction. Conceivably, antegrade intussusception might be prevented by allowing the tube to be freely propelled through the intestine, without fixing the tube to the patient. Finally, some of the reported deaths in the series were in patients in whom there was an inordinate delay in diagnosis of intussusception with an indwelling intestinal tube. The presence of an indwelling tube provided a false sense of security in some instances, and contributed to the delay in diagnosis and appropriate surgical management.

Conclusion

Intussusception is a rare but well documented complication of intestinal intubation which can occur with the tube in place, or following its removal. Although the intussuscepted segment can usually be surgically reduced, a bowel resection may sometimes be necessary. Delay in diagnosis and appropriate surgical treatment with a concomitantly increased morbidity and mortality are linked to a low index of suspicion. Prevention of this complication may be possible by a gradual, staged removal of the tube without suction and avoidance of fixation of the tube to the patient. ◀

References

- Mersch, W. J., Block, M. D.: "Intussusception Following Intestinal Intubation," *Arch. of Surg.*, 81: 887-889, 1960.
- Smith, B. C.: "Experiences with the Miller-Abbott Tube," *Ann. Surg.*, 122:253, 1945.
- Harris, F. I.: "Intestinal Intubation in Bowel Obstruction. Technique with a New Single Lumen Mercury Weighted Tube," *Surg. Gynec. & Obst.* 81:671-678, 1948.
- Moscarella, A. A.: "Jejunal Intussusception Unusual Complication of the Use of an Intestinal Tube," *Amer. J. Surg.*, 102:83-85, 1961.
- Sower, N., Wratten, G. P.: "Intussusception Due to Intestinal Tubes. Case Reports and Review of Literature," *Amer. J. Surg.*, 110:441-444, 1965.
- Ginzburg, L., Friedman, I. H.: "Delayed Intussusception. Following Removal of Long Intestinal Tube, with Observation on its Use," *New York State J. of Medicine*, 74:2009-2013, 1974.
- Nichols, H. M.: "Intussusception Occurring After Intubation Small Intestine," *Northwest Med.*, 45:924-925, 1946.
- Warren, K. W., Cattell, R. B.: "Stenosis of the Intestine after Strangulated Hernia with Fatal Complication Following Intestinal Intubation," *Am. J. Surg.*, 75:729-732, 1948.
- Dunn, D. D., Shearburn, E. W.: "Jejunal Intussusception: Unusual Complications of the Use of the Miller-Abbott Tube," *Surgery*, 26:833-836, 1949.
- Deterling, R. A., O'Malley, W. K., Knox, W.: "Intussusception in the Adult, with Emphasis on Retrograde Type," *Arch. Surg.*, 67:854-864, 1953.
- McGoon, D. C.: "Intussusception: A Hazard of Intestinal Intubation," *Surg.*, 40:515-519, 1956.
- Remine, W. H., Pontius, J. G.: "Intussusception of the Small Bowel as a Complication of the Use of a Long-Limbed Intestinal Tube," *Proc. Staff. Meet., Mayo Clinic*, 33:451-452, 1958.
- Poppel, M. H., Brinsley, B.: "Ileal Intussusception as Result of Intestinal Intubation," *JAMA*, 169:1189-1190, 1959.

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An Early Cancer Detection Questionnaire For Public Education Distribution

BY LARRY S. MILNER, M.D., F.A.C.P./NORTHBROOK

A questionnaire about the presence of suspicious signs of early cancer was delivered to 25,000 homes. The questionnaire was used by 1003 persons in 486 households. Of those responding, 24% indicated that they had at least one positive response to the questions, indicating a need for examination. This method of patient education has a definite place in cancer prevention programs throughout the state.

Although many advances have recently been made in the treatment of cancer through surgery, radiation, chemotherapy, hormone therapy, and immunotherapy, the best route for cancer cure today is still early detection before metastases has occurred. Physical examinations by allied health personnel can aid in the early detection of certain cancers, especially those externally visible, but the recognition of early signs and symptoms by the patient is a vital link in this discovery process. If the patient does not see his physician early, when the symptoms have just begun, the hope for a cure diminishes.

Many educational devices have been used to inform the public of these signs and symptoms. The American Cancer Society has been active for many years in the field of public education and the seven early signs of cancer published by this organization are well known. Such a list is brief and incomplete, however, and by itself cannot be expected to uncover a significant number of potential cancer victims. To achieve this goal, a more complete systematic list of all the danger signals would be needed so that patients can test themselves at the time of the educational process.

The appended questionnaire was designed by the Tumor Board of Skokie Valley Community Hospital under the direction of the author. It's

primary purpose was to teach the general public some of the primary signs and symptoms of cancer in a number of organ systems (Figure 1). Vague symptoms or those commonly associated with benign disease were not included. Because many of the early signs of cancer can result from both benign and malignant causes, it is important that undue alarm not occur over symptoms which often reflect unimportant problems. The items included in this questionnaire fulfilled our criteria: a yes answer indicates immediate physician examination and advice. It was decided that these questions would not burden the health care system by setting up unnecessary appointments for problems with a low risk of abnormality.

Once the questionnaire was completed, the problem of getting large numbers of people to read it was faced. This difficulty includes both the apathy of the general public toward health-related programs and the economics of delivering the questionnaire to thousands of households.

The apathy of the general public is a primary problem in many early cancer detection programs. Many people are subconsciously aware of cancer-related symptoms and yet are either too frightened or too stoic to see a physician. Many feel isolated from illness and pass off problems without asking for professional advice. Although lip service is often given to support of the American Cancer Society through general donations, individual specific involvement in health screening programs is very deficient.

The questionnaire format was designed to overcome some of this apathy. It was felt that direct participation by the individual would be more likely to elicit a response than would educational material alone. By directly answering yes or no to each specific question, and marking it on the paper, the importance of the answer



LARRY S. MILNER, M.D., F.A.C.P., is a staff physician at Skokie Valley Community Hospital and Highland Park Hospital. Doctor Milner is board certified in internal medicine, hematology and oncology. He is a clinical associate in medicine with the University of Illinois School of Medicine and a member of the board of directors of the American Cancer Society, North Shore Unit.

Figure 1

**SKOKIE VALLEY COMMUNITY HOSPITAL SPONSORS
EARLY CANCER DETECTION QUESTIONNAIRE**

Skokie Valley Community Hospital, in cooperation with the Skokie Board of Health, is sponsoring a questionnaire designed to point out some of the signs and symptoms of the early stages of cancer. A "yes" answer to any of these questions does not mean that you are likely to have cancer in any of the organs listed, but it does point out that an evaluation by your physician would be indicated. If we are ever to conquer cancer by early detection and cure, it is vitally important that the patient contact his physician at the earliest sign or symptom. Although the questions that follow do not list every abnormality of concern, they do point out the most common. If you have not consulted your own doctor for any of these questions to which you answer "yes," please call to request an appointment. If you do not have a physician, you may call Skokie Valley Community Hospital, 677-9600, Ext. 200, or the Chicago Medical Society, 922-0417, for a list of physicians in your area that are accepting new patients. This questionnaire should be retained for your personal use. So that the hospital can determine whether or not you found it helpful, please return the attached card.

		YES	NO
SKIN	Do you have a mole that has bled, enlarged, or changed color in the past 6 months?	_____	_____
	Do you have a sore that has not healed for one month or more?	_____	_____
	Do you notice frequent black and blue marks on areas that have not been bruised?	_____	_____
HEAD AND NECK	Have you had a sore throat or difficulty in swallowing for more than one month?	_____	_____
	Do you have any white or red sores in your mouth for more than one month?	_____	_____
	Do you have hoarseness or any change in your voice for more than one month?	_____	_____
	Do you have a lump in your neck that you can see or feel?	_____	_____
BREASTS	Have you ever had X-ray treatments to your face or neck?	_____	_____
	Do you have a lump in either breast that has not recently been examined by your physician?	_____	_____
	Do you have any recent change in the skin of either breast or nipple?	_____	_____
STOMACH AND INTESTINES	Do you have any discharge from the nipple that has not been examined by your physician?	_____	_____
	Have you lost more than ten pounds in the past six months without dieting?	_____	_____
	Have you been nauseous or had recurrent abdominal pains for more than one month?	_____	_____
	Have you had black, tarry stools or fresh blood on the stool?	_____	_____
LUNG	Have you noticed any recent change in your bowel movements such as recurrent diarrhea, constipation, or change in the size of your stool?	_____	_____
	Have you coughed up blood in the past month?	_____	_____
	Do you have a persistent cough that you have not had examined?	_____	_____
GENITO- URINARY SYSTEM	Have you had two or more episodes of pneumonia this year?	_____	_____
	Have you had blood in the urine that has not been evaluated?	_____	_____
	Have you had a chronic fever for which you have not seen your physician?	_____	_____
	Do you have pain or swelling in either testicle?	_____	_____
FEMALE SEX ORGANS	Do you have any change in vaginal bleeding or spotting between menstrual periods?	_____	_____
	Do you have a persistent pain or fullness in the lower part of your abdomen?	_____	_____
	Has it been more than one year since you had your last Pap test?	_____	_____
	Was your mother ever treated with hormones during a pregnancy?	_____	_____

was amplified and the need for an examination emphasized. As will be seen, the percent of people giving positive answers was remarkable.

The second problem, cost effectiveness, is also an important issue in any mass screening program. Mail postage and preparation costs are quite high and if thousands of forms were to be distributed, an alternative means of delivery was felt necessary.

This problem was discussed with the Skokie Board of Health under the direction of Dr. Samuel Andelman. Many communities have active public health departments involved with educational programs for their constituents in a variety of health-related problems. In Skokie, the Board of Health sends a monthly newsletter to each household in the village. This method is more economical than mail delivery and is part of the Health Department budget. By combining our questionnaire with one of the monthly deliveries, the majority of Skokie residents were given access to the questionnaire in a very cost effective way. Cooperation between the hospital and the health department can save money by utilizing existing facilities in each institution for health-related problems.

This program was carried out over a four-day period from November 25-28, 1977. A postcard was attached to each questionnaire asking four questions that were relevant to studying the effects of this approach (Figure 2). The results are tabulated below.

Results

A total of 25,000 forms were delivered and 486 postcards (1.9%) retrieved in the following four weeks. People were asked to mark how many persons in each household used the questionnaire

Figure 2

RETURN POSTCARD

Did this questionnaire alert you to possible early symptoms of cancer?

☐ Yes ☐ No

Did you answer yes to any of the questions listed?

☐ Yes ☐ No

Are you planning to see your physician because of this questionnaire?

☐ Yes ☐ No

Do you think this type of questionnaire is helpful?

☐ Yes ☐ No

How many people in your household used this questionnaire?

and this number totaled 1003 for an average of 2.04 persons per household. Since only one answer was provided for each question, however, the percentage of positive responses will indicate the percent of households responding to the question rather than the percent of occupants.

A retrieval rate of 1.9% was considered quite good when compared to an American Cancer Society survey sent to similar areas in 1977. This survey on physical examination checkups was mailed to 20,000 homes and a postcard asking for a response was inserted. In this situation, the card did require return postage and of the 20,000 forms distributed, only 80 cards were returned for a 0.4% retrieval rate.

The first question asked on the postcard was "Did this questionnaire alert you to the possible early symptoms of cancer?" This question was intended to find out whether people were educated by this approach. There were 465 answers obtained and 372 were "yes" which is an 80% positive response rate. This indicates that a large majority of the people responding felt that the program was of educational value.

The second and third questions were designed to find out whether such a survey would help patients discover early signs of cancer and possibly get a physical examination leading to early detection of their problem.

Question two read: "Did you answer yes to any of the questions listed?" There were 483 answers recorded and 116 or 24% said yes.

Question three read: "Are you planning to see your physician because of this questionnaire?" There was 473 responses and 91 or 19% answered yes.

The fourth question on the postcard was designed to test the overall effect of the program. It asked: "Do you think this type of questionnaire is helpful?" There were 470 people answering this question and 462 or 98% said yes: a resounding support of the program.

Discussion

As indicated by the overwhelming support from question four on the postcard, this approach to patient education on early cancer detection appears to be a valuable aid and should be extended to other areas. Fully 98% of the people filling out the postcards felt that they learned something from the questionnaire.

The most surprising part of the response, however, was the large number of people stating that they had answered yes to one of the questions listed in the questionnaire.

These questions were selected by eliminating most which did not appear to indicate a potentially serious problem. Under these circumstances, a 24% positive response was remarkable. It indicates that many patients are having serious symptoms whether they are seeing their physician or not. Since 25 of the 116 people who answered yes to one of the questions said they were not going to see their physician, some explanation should be further investigated. Although some of these patients may have had chronic complaints for which previous evaluations were negative, it is hard to imagine that this alone would account for the difference. I think that much of the problem stems from a common inability to accept illness, and it is this type of reaction that will need future evaluation.

We cannot tell at this time if any patients actually were found to have cancer and ultimately were treated because of this early detection program. Perhaps this can be included as part of the response material in future studies, but I feel that the results of this survey indicate a definite place for programs of this kind in other areas of our state. I hope this paper will encourage others to develop similar techniques and that cooperation will lead to further procedural refinements. ◀

Viewbox,

(Continued from page 14)

DIAGNOSIS: (D) Arterio-Enteric Fistula

The angiogram demonstrates irregular areas of widening in a jejunal branch of the superior mesenteric artery (SMA) (arrow). This branch has been pulled into an abnormal position on the right side of the SMA, presumably because of prior small bowel resection for ischemic, necrotic small bowel secondary to an adhesion. Massive extravasation of contrast with visualization of small bowel mucosal folds is demonstrated on the delayed angiograph films. At the time of this study the patient was experiencing massive rectal hemorrhage. An attempt to control the hemorrhage was made by the infusion of pitressin, with no apparent influence on the rate of blood loss. It was then elected to operate on the patient instead of attempting to embolize the bleeding jejunal vessel.

At operation, the site of bleeding was found to be very near the point of previous small bowel anastomosis. An abscess was present at this site and had eroded through the vessel wall as well as establishing a communication with the small bowel. When the upper GI tract (proximal to the Ligament of Treitz) has been eliminated as a

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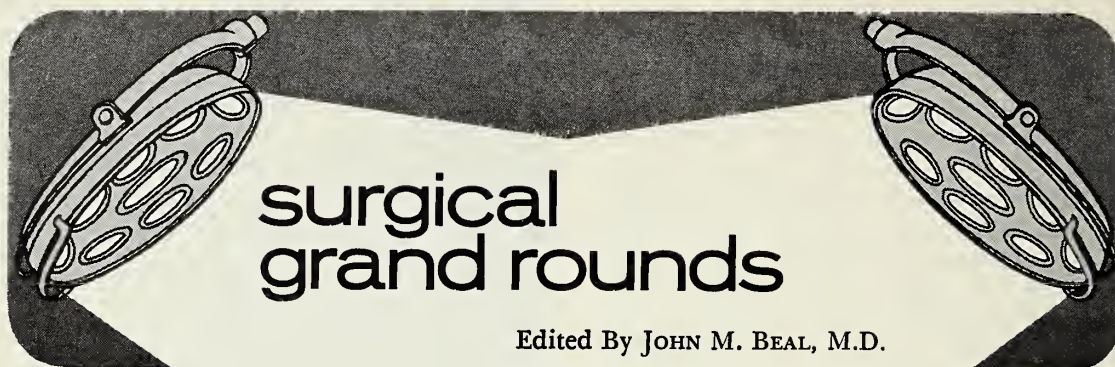
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cause of rectal hemorrhage, the most common cause of massive rectal bleeding is colonic diverticulosis most frequently proximal to the splenic flexure. However, a wide range of other lesions involving the small bowel distal to the Ligament of Treitz as well as the colon can be responsible. Other causes include inflammatory bowel disease, neoplasm, Meckel's diverticula, and vascular abnormalities.

Angiography has played an increasing role in the diagnosis of gastrointestinal hemorrhage. It frequently pinpoints the exact site of bleeding, allowing direct but limited surgical therapy or treatment by vasoconstriction infusion or embolization of the bleeding vessel by a wide variety of materials.

References

1. Beychok, I. A.: "Precise Diagnosis in Severe Hematochezia," *Archives Surg.*, 113:634-636.
2. Casarella, W. J., Galloway, S. J., Toxin, R. N., Follet, D. A., Pollack, E. J. and Seaman, W. B.: "Lower Gastrointestinal Tract Hemorrhage: New Concepts Based on Arteriography," *Am. J. Rad.*, 121:352-368.
3. Stanley, R. J., Wise, L.: "Arteriography in Diagnosis of Acute Gastrointestinal Tract Bleeding," *Archives Surg.*, 107:138-143.
4. Walter, J. F., Bookstein, J. J., Kramer, R. A., Cannon, W. B., Trallope, M. L. and Jamplis, R. W.: "Therapeutic Angiography," *Archives Surg.* 113:432-438.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 21, 1978.

Renal Failure in Surgical Patients

Dr. Frank Krumlovsky: This discussion of renal failure will be divided into several areas. First, I will discuss the approach to the patient with acute renal failure. We will consider some of the causes of acute renal failure, and how to diagnose them, followed by some of the therapeutic approaches. Second, I will discuss briefly the pathophysiology of acute tubular necrosis, which is by far the most common cause of acute renal failure encountered in the surgical patient. Third, I will discuss the basic management of the patient who has developed acute renal failure. Finally, a few remarks will be made about drug management in the patient with renal failure, and drug dosage adjustment in such patients.

Acute renal failure can be defined as an acute deterioration in the preexisting level of renal function. It is important to keep this definition in mind, because a patient may already have some level of preexisting renal insufficiency. If his renal function deteriorates further, it is very easy to conclude that this represents a progression of his underlying chronic renal failure, rather than addressing the fact that acute renal failure may be superimposed upon preexisting

chronic renal failure.

When acute deterioration of renal function has been detected, the next step is categorization into oliguric or anuric renal failure. Oliguric is defined as a urine output less than 600cc per day but greater than 50cc per day. This is usually associated with either acute tubular necrosis or incomplete obstruction. I would like to emphasize that acute renal failure due to obstruction can be associated with a normal volume of urine output. There is a misconception that if a patient has a normal urinary output and is in renal failure, obstruction can be eliminated as a cause. This is simply not true. It is possible to put out a normal urine output and still be in renal failure through an incomplete obstruction, for reasons that will be discussed later. Anuria is urinary output less than 50 or 100cc per 24 hours, and usually represents either complete obstruction, or cortical necrosis.

Causal Classification of Acute Renal Failure

The classic causal classification of acute renal failure is prerenal, postrenal, and renal. In prerenal azotemia, the problem is renal hypoper-

fusion due to either hypotension or intravascular hypovolemia. Intravascular hypovolemia and decreased effective renal blood flow will result in prerenal azotemia. It is important to recognize that the effective renal blood flow in a given patient is related to that patient's preexisting blood pressure and the preexisting status of his renal microvasculature. What is hypotensive for one person may not be hypotensive for another. The hypotension may not be obvious. The blood pressure may be 140/80, but if that patient previously was hypertensive and has renal disease, *e.g.* arteriolar nephrosclerosis, he may well require a higher perfusion pressure because of his preexisting hypertension, and apparently normal blood pressures may be hypotensive as far as his kidneys are concerned.

Postrenal acute renal failure is obviously caused by obstruction. This may be incomplete or complete. As I pointed out earlier, acute renal failure may occur with BUN levels of 100 and 150 mg/100 ml, clearcut acute renal failure with normal urine output, 2-3 liters a day. You may ask, "Why does this happen?" The reason is that in the presence of incomplete obstruction, increased intratubular pressure develops behind the obstruction. This increased intratubular pressure may force enough urine out beyond the obstruction to maintain a normal urine volume. However, because of the increased intratubular pressure, there will be increased diffusion of urea and other filtered waste products, as well as a decrease in the variable filtration rate because of the increased intraluminal pressure. Obstruction must always be ruled out. Intravenous pyelograms and nephrotomograms are useful. In the patient with far advanced severe renal insufficiency, we are using ultrasound with increased frequency. Renal ultrasound is probably the easiest way to rule out acute obstructive uropathy because it is very easy to visualize the collecting system with ultrasound. A dilated collecting system is diagnostic of obstructive urography, and avoids the necessity for retrograde pyelography (which has been almost abandoned for this purpose) or exposing the patient to contrast media, which itself may be nephrotoxic.

Complete obstruction obviously results in anuria. It is important to recognize complete obstruction within 10 to 12 days. After that period of time, there will be an irreversible increment of renal function which is lost, and will not be recovered by relief of the obstruction. If you relieve a complete obstruction before that time, you will get almost complete restoration.

Renal causes of acute renal failure can be divided into tubular and cortical problems. Tubular causes of acute renal failure (acute tubular necrosis) are due to two basic mechanisms. One is ischemia. Ischemia is caused by hypotension or hypovolemia. The only difference is that here they have persisted longer or are of a more severe degree. There is a continuous spectrum between prerenal azotemia and acute tubular necrosis. In prerenal azotemia, renal function will immediately return to normal as soon as the hypotension or hypovolemia is corrected. It is a functional rather than an anatomic problem. Once it is merged or progressed into acute tubular necrosis (ATN), there is tubular structural damage. The recovery period may vary from days to weeks. It is impossible to say what degree of hypotension or hypoperfusion will result in this progression from prerenal azotemia to ATN. It depends on the age of the patient, preexisting blood pressure, and preexisting renal hypervasculature.

The second major cause of ATN is the use of nephrotoxic drugs, of which the amino glycoside antibiotics are probably the most important. The cortical causes of acute renal failure include glomerulonephritis, which is beyond the scope of our discussion here. The second major cause of cortical necrosis is mechanical obstruction of the renal vasculature. This is in contradistinction to tubular necrosis, which is usually not caused by a mechanical obstruction, but by hypotension or hypovolemia. Cortical necrosis, however, is usually due to mechanical obstruction of the renal vasculature, either the renal macrovasculature, such as a dissecting aneurysm or renal artery embolus, or occlusion of the renal microvasculature. The most common cause of the latter is disseminated intravascular coagulation from a systemic vasculitis, bacteremia, or microemboli from atherosclerotic plaques.

Nephrotoxic Drugs

There is a long list of drugs which may cause nephrotoxicity, but I would point out that there are two kinds of nephrotoxic drugs. One includes drugs which cause a dose-related direct nephrotoxicity. The most important agents in this category are the aminoglycoside antibiotics. Another shorter list of drugs cause acute renal failure on the basis of a hypersensitivity, interstitial nephritis, which is not dose related. The most important drugs of this category are penicillin and Lasix® (furosemide). If a patient who is receiving Lasix® develops acute renal failure, the possibility of Lasix® acute interstitial nephritis

must be considered.

Another major cause of acute renal failure that we have encountered is that secondary to iodinated contrast media. Patients who have had angiography, intravenous pyelography, or cholecystography have developed acute renal failure after exposure to these iodinated contrast agents. The patients that we reported had BUN levels that increased from a mean of 2.5 to 7.2mg.%. Among the factors that seem to predispose to nephrotoxicity from iodinated contrast agents are multiple sequential studies at close intervals. These patients had gallbladder studies one day, urograms the next day, and perhaps angiography the third day. Other patients at high risk were those who were dehydrated from their underlying disease, and perhaps had reported nausea or vomiting. Others were in congestive failure with resultant low cardiac output and low renal perfusion, or were hypoalbuminemic with decreased effective intravascular volume, or had some renovascular problem, nephrosclerosis, vasculitis or diabetes, all of which compromise renal perfusion. Multiple radiologic studies plus renal hypoperfusion was almost invariably present in the patients who developed acute renal failure after iodinated contrast agents. The probable pathophysiologic mechanism is uricosuria since the iodinated contrast agents are uricosuric drugs. They cause increased urinary uric acid excretion. When this occurs in a dehydrated, hypoperfused patient, urate precipitates out in the intrarenal collecting system and causes intrarenal obstructive uropathy. The collecting ducts become plugged with urate deposition. Preventive measures are obvious. The patients should be adequately hydrated and multiple sequential studies should be avoided. Particular care is required in the high risk group of patients that I have outlined.

Discussion

In summary, when a patient develops acute renal failure, the first effort should be to place him into one of the three categories.

Why is it important? It is especially important from the surgical standpoint to recognize that a patient has prerenal azotemia, since proper treatment will prevent progression to acute tubular necrosis.

The usual problem is to distinguish prerenal azotemia from acute tubular necrosis. Once acute tubular necrosis develops, therapy is limited. Thus, the distinction between prerenal azotemia and acute renal failure is important.

The following guidelines are important in this differentiation. Perhaps the most important is the urine sodium concentration. Urine sodium concentration can be determined from a random sample of urine. It does not require a 24 hour or 12 hour collection. In renal failure, the patient is unable to vary his urine sodium excretion hour to hour, so you do not need a long collection period.

A urine sodium concentrate of less than 30 mEq/L is highly suggestive of prerenal azotemia. In ATN, the urine sodium concentration is usually between 40 and 70 mEq/L. This is totally invalid as the patient has received Mannitol® or Lasix®. One of the most frustrating things on the Renal Service is to be asked to evaluate a postoperative patient with renal failure after you are told, "We've given him Mannitol® and Lasix® and nothing works. Now we want you to help us." It is very difficult to help when our guidelines have been masked by the drugs administered.

The second most important thing on this list is urine osmolality and/or the urine specific gravity which parallel each other. In ATN, the osmolality tends to approach that of serum, varying from 300 to as high as 500. In prerenal azotemia, it is usually greater than 800 and approaches maximum urine concentrating ability which is 1200 milliosmols.

The increased BUN creatinine ratio in prerenal azotemia versus ATN is well known. ATN is less likely to respond to Mannitol® than is prerenal azotemia.

Pathophysiology of Acute Tubular Necrosis

Let me digress for a few minutes to comment on the pathophysiology of acute tubular necrosis. This digression may have some therapeutic implications in the future. There have been several mechanisms postulated as to what happens in ATN. One is that the tubules get plugged up from sloughing of necrotic tubular epithelium which plugs the lumen of the tubule of the nephron, resulting in oliguria and renal failure. Most evidence now favors a lesser role for this particular mechanism. There may be some degree of intratubular obstruction, but most evidence argues against the significance of this mechanism. Another pathophysiologic mechanism is back diffusion. This means that the tubular epithelium is damaged and ischemic. Thus, there is back diffusion of the tubular filtrate (urea, creatinine, etc.) which instead of being excreted, leaks back

and is reabsorbed. Thus, oliguria and azotemia occur. Most evidence argues against this mechanism as well. Most evidence favors a vascular mechanism. There appears to be arteriolar vasoconstriction in acute renal failure. The mediation of this is not clear.

If you perform studies which reflect cortical and tubular blood flow in a normal patient and in a patient with renal failure, it is apparent that the problem in ATN is a lack of cortical blood flow consistent with arteriolar vasoconstriction. Where angiograms are performed in patients with ATN, obliteration of the renal microvasculature is observed. The same thing can be demonstrated by the injection of silicone, which shows the loss of the distal microvasculature in ATN.

What is the mechanism? Why should there be arteriolar vasoconstriction? There is evidence to incriminate the renin angiotensin system. There are a number of experimental models that indicate that the renin angiotensin system is activated in the presence of ATN and may be responsible for the arteriolar vasoconstriction to which I have alluded.

One would think all this could be prevented by the administration of propranolol, a renin inhibitor, by an angiotensin inhibitor, or by a vasodilator. These things have been tried, and unfortunately, did not prevent ATN.

What to do to prevent ATN? Obviously, the first thing is to prevent hypotension and hypovolemia, or to recognize and correct hypotension early. What if the patient is already developing early ATN? Is there anything you can do to prevent full blown ATN? Is there evidence that Mannitol and Lasix do any good when the patient becomes oliguric? First regarding Mannitol, there is good evidence that Mannitol is effective in preventing or modifying the development of early ATN, if it is given early enough. Some of the evidence for this is based on the hypothesis of arteriolar endothelial swellings secondary to interstitial edema. There has been some work which casts doubt on the importance of this particular study, but it is, I think, still relevant. If you make an animal ischemic, the thickness of the endothelial cells in his interstitial renal vasculature will double. One can speculate that if there is transient arterial occlusion or transient renal hypoperfusion for any reason, there will be renal ischemia, intercellular and interstitial edema. As a result there is cell wall breakdown, with further vascular occlusion and tissue death which is ATN. If you give these patients Man-

nitol, what happens? Mannitol prevents the endothelial cell swelling because it draws water out of the cell by osmotic action, tending to permit more normal or adequate renal perfusion and tending to minimize subsequent development of ATN. So, there is rather sound physiologic evidence not only for giving Mannitol early in the course of ATN to try to prevent further progression, but also for giving Mannitol prophylactically in high risk surgical patients. For example, in an elderly patient who has bad or pre-existing hypertension who is being subjected to an elective surgical procedure, one can make a good case for giving that patient Mannitol, especially if it is a vascular procedure. Administer 12½ grams IV on cell to the operating room, and another 12½ grams with introduction of anesthesia. Remember, the patient who is scheduled for operation gets many things that tend to cause ATN. Oral fluids are withheld the night before operation; vasodilatory pre-medication is often given. He is often given an anesthetic which may have a vasodilatory effect. The patient, then, often vasodilated and volume-depleted and with the first volume lost during the operation, he may vasoconstrict to maintain his blood pressure. Although the blood pressure may not fall, he may be subject to major renal hypoperfusion. A relatively small intraoperative blood loss may be enough to compromise his renal perfusion and result in postoperative mild, moderate, or severe ATN.

Mannitol obviously expands blood volume and probably has some effect on decreased blood viscosity. What about Lasix? Lasix is frequently given when a patient is becoming oliguric. Does it do any good? I think the evidence is overwhelming that it does not. To the best of my knowledge, there is no good evidence that Lasix will alter the course of ATN. If a patient has renal failure, is volume overloaded and in pulmonary edema, and you want to deplete fluid to relieve pulmonary edema, Lasix is effective. But if you are giving Lasix to prevent the development of ATN, that is wrong. The reasons are clear. Lasix is a drug which delivers more sodium to the distal nephron. It blocks sodium reabsorption in the ascending loop of Henle. This is one of the stimuli that activates that renin angiotensin system, thereby causing arteriolar vasoconstriction and tending to decrease renal blood flow. Through this mechanism, it may decrease renal blood flow and make acute renal failure more likely.

Second, the diurectic response to Lasix may

deplete intravascular volume and if this is not corrected, ATN is more likely.

Third, there is recent evidence that Lasix destroys the ability of the kidney to autoregulate. As you know, the kidney has an ability to adjust renal blood flow based on perfusion pressure. Recent studies show that Lasix interferes significantly with the ability of the kidney to vasodilate in compensation for hypoperfusion. So, it may actually destroy the kidney's adaptor response to hypoperfusion.

The major factor in the prevention of acute renal failure postoperatively is to have the patient well hydrated before operation. High risk patients should certainly be started on intravenous fluids the evening before surgery to prevent any volume depletion at the time they are taken to the operating room and subjected to the hypoperfusion effects of premedications and anesthetic agents that I have discussed.

Dialysis is often used early in renal failure. The chief indications are a blood urea nitrogen level greater than 100mg.% or elevation of serum potassium levels or acidosis that cannot be managed conservatively. It must be emphasized that one must always rule out obstruction. Never forget that sometime during the first week or ten days after operation, you must exclude obstruction by some mechanism if renal failure is present. Formerly, this was difficult because the patients were often sick. With ultrasound, this can be accomplished with relative ease and very atraumatically.

Dr. Julius Conn, Jr.: When we use the Mannitol preop even in high risk patients overnight, anesthesia contends that we are getting an inordinate drop in blood pressure with induction of anesthesia. They are concerned that because of the Mannitol diuresis, we are bringing them to the operating room hypovolemic. As a result, we've tried giving them albumin, just before surgery. If we give them albumin or additional fluids to compensate for the diuresis, are we defeating our purpose, will they develop interstitial edema and hypoperfusion from adding fluid at the same time that we diurese them with Mannitol?

Dr. Frank Krumlovsky: No, not at all. What you are doing by giving them Mannitol is to provoke osmotic diuresis. Obviously, this will tend to deplete the intravascular volume. Administering salt-poor albumin—actually, or if they are dehydrated to begin with, 5% albumin and saline or albuminosol—will maintain their volume in the interstitial space but will also

supply them with circulating volume. Salt-poor albumin is most useful if someone has edema or excess interstitial volume that you are trying to mobilize into the intravascular space. If they are already dehydrated, they would need both albumin and fluid volume for the albumin to work on.

Dr. Julius Conn, Jr.: So, we are not defeating our purpose by giving them volume plus Mannitol?

Dr. Frank Krumlovsky: Absolutely not. You are helping because the Mannitol will help keep it in the intervascular space and out of the arteriolar endothelial cells. So, you are maximizing effective intervascular volume.

Dr. Julius Conn, Jr.: You said that Lasix is not going to prevent ATN. Is there harm if you are giving Mannitol to also give Lasix?

Dr. Frank Krumlovsky: Well, why are you giving the Lasix? If you are administering Lasix because the patient is volume overloaded, has an elevated pulmonary artery pressure, or is developing edema, that is fine. But if you are giving Lasix because you are concerned that cardiac output is poor and are trying to prevent ATN, I would take issue with giving Lasix. The Lasix, if it works, will deliver more sodium to the distal tubule, activate the renin angiotensin system, cause renal vasoconstriction, and thereby decrease renal perfusion. This will, in itself, tend to cause ATN. It will also wipe out the renal autoregulatory mechanism as I have discussed and will tend to destroy the kidney's ability to compensate for hypoperfusion.

Dr. L. Michaelis: Is this specific for Lasix or any diuretic?

Dr. Frank Krumlovsky: I mentioned it for Lasix because Lasix is used so widely, but others can produce the same damage.

Dr. Stuart Poticha: If you have a patient who has been chronically ill for a time, is dehydrated and has an overlying acute illness requiring urgent surgery, he may frequently have periods of poor perfusion and will become oliguric. If they are severely dehydrated prior to surgery, my experience has been that Mannitol does not work very well because there is no fluid in their intracellular compartment to mobilize. Those are the patients with whom you are reluctant to keep pushing fluids with nothing coming out. We have used Lasix just to get some urine out so that we know that there is some renal function. In other words, how much fluid should you give a dehydrated patient before you start Mannitol?

Dr. Frank Krumlovsky: That's easy. When

their pulmonary artery pressure gets above 8cm. of water.

Dr. Stuart Poticha: You don't always have pulmonary artery pressure available.

Dr. Frank Krumlovsky: It comes down to the clinical assessment of hydration and there are four or five major parameters that you can use clinically even without the CVP or PAP. Probably the most useful are neck veins. If the patient is lying supine and you empty their neck veins and then keep them occluded distally, watch how they fill from below. Then, you can estimate the height of their venous column above their right atrium. If you do this on enough patients, you get a good feel for it and you can estimate what their CVP is. You know the CVP is not the same as the pulmonary wedge pressure and that RAP is the same as the CVP, so we are two orders removed from the ideal world. But it is not that far removed. If you look at neck veins and see that the patient has no visible neck veins when lying flat, you know that their CVP is very close to 0. And if you give them fluids, you just have to continue until their neck veins start coming up. You don't have to say that this is a PAP of 6cm. of water. But you can see it's risen

from zero. There are neck veins, there are rales and peripheral edema. Granted you do not like to see them get a lot of rales, but one or two never hurt anyone and it tells you that you have given enough volume. Of course the thing to do is to put in either a cup line or a Swan-Gantz catheter and monitor fluid replacement and cardiac output accurately. However, your point is well taken—that giving Mannitol to someone who is dehydrated is not good, but I still have to take issue with the practice of giving Lasix to someone who looks dehydrated. What you want to do is correct their dehydration, and then if there is no urine output give Mannitol. I think you can do it safely with the clinical parameters that I outlined without having to put in a Swan-Gantz catheter.

Dr. Julius Conn, Jr.: Are you using dopamine-albumin combination to increase renal blood flow?

Dr. Frank Krumlovsky: The rule is that you replete intravascular volume before you start dopamine and then infuse whatever fluid is needed to replete fluid volume. Salt-poor albumin given prior to and with Dopamine will help mobilize edema fluid. ◀

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Marijuana in Medical Research

The so-called "medical marijuana" law which went into effect on January 1, 1979, is widely misunderstood by physicians and pharmacists, as well as the general public, reports the Illinois Dangerous Drugs Commission. Administration of the new law (Public Act 80-1426) is far more complex than previous media reports have indicated. In order for any cannabis product to be used for the treatment of glaucoma, chemotherapy side effects, or any other condition, the following requirements must be met:

1. Applying physicians must obtain a Schedule I Research Authorization from the Federal Drug Enforcement Administration (DEA);
2. A research protocol and application must be submitted to the Dangerous Drugs Commission (DDC), where a medical review panel will rule on the appropriateness of the proposed treatment;
3. Upon approval by the DDC's medical review board, which will be voluntarily assembled with the assistance of the Illinois State Medical Society, approval of the Illinois Department of Law Enforcement will be obtained, thus clearing the *legal* roadblocks for medical administration of cannabis products.

There remain additional practical problems, however, before the first dose of cannabis will be available to patients. Under Federal law, the only legitimate source of cannabis products at present is the National Institute on Drug Abuse. Questions have been raised by the Institute concerning the availability of adequate supplies to meet research demands, as well as ongoing changes in the form of the product as research continues. It is known that the cannabis medication will *not* be dispensed through pharmacy prescriptions.

The Dangerous Drugs Commission and the Illinois State Medical Society are working together to implement the law in a way that will benefit the patients it is intended to help. Physicians and prospective patients must understand, however, that the administration of the statute will not be a simple matter of prescribing a new drug, as early press reports have apparently led many to believe. Detailed procedures should be available shortly from either the Dangerous Drugs Commission or the Illinois State Medical Society. Physicians wishing to consider this form of treatment should begin now by obtaining a Schedule I Research Authorization from DEA. ◀

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1 1/2 hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, and the Oak Park clinic is \$3.00 for residents and \$6.00 for non-residents. The remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago, 60606 (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a routine basis, and urges Illinois physicians to notify their patients of this service.

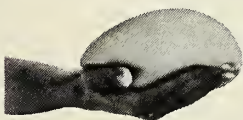
March 11	Seventh Day Adventist Church	Hinsdale
March 12	Christ Hospital	Oak Lawn
March 26	Y.W.C.A.	Rockford
May 13	Seventh Day Adventist Church	Hinsdale
May 14	Christ Hospital	Oak Lawn
July 8	Seventh Day Adventist Church	Hinsdale
August 6	Y.W.C.A.	Rockford
September 9	Seventh Day Adventist Church	Hinsdale
September 10	Christ Hospital	Oak Lawn
November 5	Y.W.C.A.	Rockford
November 11	Seventh Day Adventist Church	Hinsdale



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Medical Disciplinary Board Actions

The following "Recommended Steps for Initiating Medical Society Disciplinary Action and Reporting to the Medical Disciplinary Board" were adopted by the ISMS Board of Trustees at its meeting of February 5, 1978. The Board further mandated that this information be published in *Action Report* and the *Illinois Medical Journal*, along with the names of those physicians who were disciplined by the Department of Registration and Education.

During 1978, the Department of Registration and Education imposed disciplinary action on the licenses of several physicians.

Recommended Steps For Initiating Medical Society Disciplinary Action And Reporting To The Medical Disciplinary Board

1. Request the Directors of the Department of Registration and Education and the Department of Public Aid to notify ISMS officially of all disciplinary actions taken against physicians.
2. Request hospital medical staffs to forward to county medical societies a report on disciplinary actions taken against staff members who

- are suspected of violating the Medical Practice Act. This is not to be construed, in any way, as restricting the hospital from reporting the incident to the Medical Disciplinary Board. Such reporting should be encouraged.
3. Urge county medical societies to investigate the qualifications for continued membership of any physician who has been: (A) Disciplined by the Department of Registration and Education; (B) Suspended or terminated from the Medicare or Medicaid program; (C) Suspended from a hospital staff; or (D) Convicted of a felony.
4. Inform all physicians that suspected violations of the Medical Practice Act by their colleagues should be reported to their county medical society. All cases should be reviewed by a Society committee to determine their validity. If the review indicates reasonable grounds for further inquiry and no malice appears to be involved, the case should then be forwarded to the Medical Disciplinary Board without comment or embellishment.
5. Information relative to cases undergoing formal ethical proceedings by medical societies should not be forwarded to the Medical Disciplinary Board until those proceedings are concluded, including appeals.

FORMAL DECISIONS REGARDING DISCIPLINE, 1978

Licenses	Violation	Discipline	Date of Order
Grover Goodwin 126 West 1st Avenue Rankin, Illinois MEDICAL DOCTOR 36-12221	Chapt. 91, Sec. 16A, 4, 19 Acknowledges that he prescribed controlled substance for other than therapeutic purposes.	Voluntary and permanent retirement Consent Order 77-257	1-5-78
Hayward Foy 203 South Arlington Hgts. Rd. Arlington Heights, Illinois MEDICAL DOCTOR 36-17906	Chpt. 91, Sec. 16a. 2 Acknowledged that he was convicted in Cook County Circuit Court on February 10, 1978 of the illegal delivery of controlled substances.	Revocation Consent Order 77-15	3-17-78
Erwin Wuerfele 501 West Locust Bloomington, Illinois MEDICAL DOCTOR 36-20434	Chpt. 91, Sec. 16a, 4 Acknowledges that on May 31, 1977 he was found guilty of dispensing controlled substances not in good faith.	Revocation Consent Order 77-258	3-3-78
Robert Roth 1245 South Ashland Chicago, Illinois MEDICAL DOCTOR 36-25157	Chpt. 91, Sec. 16a (4), (12) (14) Negligent in bookkeeping and billing practices. Failed to return to the Illinois Department of Public Aid duplicate or incorrect payment checks.	Censure 77-12	3-17-78
Kandaswamy Balasubramaniyam 4640 North Sheridan Rd. Apt. 1404 Chicago, Illinois MEDICAL DOCTOR 36-54969	Chpt. 91, Sec. 1 Obtained license through fraud and misrepresentation.	Revocation 78-1	4-19-78

Theodore C. Rozema 1401 Golf Road Waukegan, Illinois MEDICAL DOCTOR 36-37405	Chpt. 91, Sec. 16a(2) Convicted in U.S. District Court, District of Massa- chusetts of the felony of extortion.	One Year Probation 77-66	4-21-78
Ernesto C. Noche 213 West First Geneseo, Illinois 61254 MEDICAL DOCTOR 36-46262	Chpt. 111, Sec. 4433(4) Pled guilty in Henry County Circuit Court to contributing to the sexual delinquency of a child.	Indefinite Suspension Consent Order 78-81	6-28-78
Aldonna Nakutis 2800 West 87th Street Chicago, Illinois 60652 MEDICAL DOCTOR 36-35374	Chpt. 111, Sec. 4441 Issued large amounts of Schedule II Controlled Sub- stances in an improper man- ner.	Revocation Consent Order 78-59	5-26-78
Andrew Miesz 990 Federal Road Houston, Texas MEDICAL DOCTOR 36-42820	Chpt. 91, Sec. 16a(2) Dept. demonstrated that he was convicted in U.S. Dis- trict Court, Southern District of Texas, Houston Division, in February, 1978 of mail fraud.	Revocation 78-37	7-14-78
Warren G. McPherson 249 South Morgan Bement, Illinois MEDICAL DOCTOR 36-32374	Chpt. 91, Sec. 16a(2) Department demonstrated that he was found guilty on Feb- ruary 24, 1977 in Circuit Court Piatt County, of failing to keep Controlled Substances record and on May 3, 1977, in the same court he was found guilty of the felony of obstructing justice.	3 Month Suspension of Medical license; 6 Month Suspension Controlled Substances License 77-253	7-20-78
Lee Foster Beamer 10315 Lyndale Ave., #203 Melrose Park, Illinois MEDICAL DOCTOR 36-039022	Chpt. 91, Sec. 11 Department demonstrated that his license to practice medi- cine was revoked in another state.	2 year Probation 77-181	8-7-78
Michael Goodman c/o Fred Rabishwa One North LaSalle Suite 2225 Chicago, Illinois 60602 MEDICAL DOCTOR 36-48593	Chpt. 91, Sec. 16a (2) Convicted of theft on No- vember 8, 1977 in Cook County Circuit Court.	Suspended Indefinitely 78-11	9-5-78
Milton Daugherty 5050 Lake Shore Drive Chicago, Illinois 60615 MEDICAL DOCTOR 36-048434	Chpt. 91, Sec. 16a(14)(12) & (14) (4) & (26) Improper billing to the Illi- nois Department of Public Aid.	Sixty (60) Day Suspension 77-11	9-22-78

Other Formal Decisions

Robert Foresman 5901 West Addison Chicago, Illinois MEDICAL DOCTOR 36-39109	Chpt. 91, Sec. 17.07 Department will restore medi- cal license on certain terms and on a probationary status.	Restore Medical license with 3 year Suspension of Con- trolled Substance Certificate + 3 year probation 78-3	3-10-78
Leslie S. Kaplan 3520 West Roosevelt Rd. Chicago, Illinois 60624	Petition for Restoration	Denied 77-264	5-9-78
John Millas 6923 Riverside Drive Berwyn, Illinois	Petition for Restoration	Restoration of Medical License; Narcotic License suspended indefinitely 77-251	5-26-78
Steven G. Shellabarger 1123 North Fourth Street Chillicothe, Illinois 61523	Petition for Restoration	Restoration of Medical License; Controlled Substances license suspended until December 29, 1980	6-16-78
Payming Leu 7257 Jeffery Blvd. Chicago, Illinois 60649 MEDICAL DOCTOR	Petition for Restoration	Denied 77-206	8-31-78
Rudolph D'Elia 6 Doby Street Hammond, Indiana MEDICAL DOCTOR	Petition for Restoration	Restored 78-14	7-20-78



Survey of House Staff Policy

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Chicago ranks in the middle of granting Housestaff benefits, according to a 1977 AAMC-sponsored study of Housestaff benefits. Members of the AAMC's Council on Teaching Hospitals

(COTH)* were polled as to housestaff benefits at their own hospitals with an 81% reply rate. Selected figures for the study as a whole and for Chicago are presented below:

House Staff Fringe Benefits

Type of benefit	Percent of hospitals providing benefits**	
	Nationally	Chicago
Life Insurance	55	58
Dental Insurance	23	8
Disability Insurance	46	64
Prescription Drugs	37	25
Parking	72	73
Vacation—(PGII figure)		
two weeks	25	8
three weeks	51	75
four or more weeks	24	17
Health Insurance		
Basic Medical		
House Staff	65	75
Dependents	49	70
Major Medical		
House Staff	60	67
Dependents	45	58
First Year Stipends in dollars (mean)	13,145	13,749

Chicago generally compares favorably to the rest of the country excepting the areas of dental insurance and prescription drugs. Any given hospital, however, may be deficient in basic employee benefits. Despite the large gains made in house staff benefits over the past few years, it is

of note that nearly half of all hospitals nationally do *not* provide life insurance, disability insurance, or dependent coverage for either basic or major medical insurance. We have come a long way, but there is still a long way to go.

*COTH SURVEY OF HOUSE STAFF POLICY AND RELATED INFORMATION 1977. AAMC, Washington, D.C. Copies of the survey may be obtained by sending \$3.50 to: Association of American Medical Colleges. Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

**refers to hospitals covering total cost of benefit at no charge to employee

EKG

(Continued from page 11)

Answers: 1. B. 2. C.

The ECG rhythm strip shows sinus rhythm with inverted P waves due to the positioning of the telemetry monitoring leads. All the PR intervals are equal. The first five beats show 2:1 AV block. Beats 5 through 8 of line one conduct on a 1:1 basis. This represents type II AV block also called Mobitz type II AV block. The diagnosis requires two conducted sinus beats in a row or changing conduction ratios, *i.e.*, 1:1, 2:1, 3:1. The PR interval here is normal, although it may be prolonged, but still remains fixed and equal in all conducted beats to the dropped P wave. It is rarely, if ever, caused by digitalis toxicity. It is frequently associated with bundle branch block. Most authors agree that type II AV block reflects disease in the common bundle or the bundle branches. The normal QRS in our patient probably represents disease in the common bundle or the bundle of His. This is reported more commonly in females. Type II AV block is regarded as a precursor of high grade or complete AV block and even asystole and sudden death. Our patient received a permanent demand pacemaker and became asymptomatic.

COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES

STARTING DATES — 1979

SPECIALTY REVIEW THORACIC SURGERY, January 29
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 2
NEUROLOGY, PART I, BASIC, February 26
BASIC REVIEW IN PSYCHIATRY, 5 days, March 12
SPECIALTY REVIEW SURGERY, PART II, March 12
CLINICAL MEDICINE UPDATE, March 19
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC
AND THROMBOTIC DISORDERS, 2 days, March 30
ADVANCES IN SURGERY, 5 days, April 9
SPECIALTY REVIEW UROLOGY, 5 days, April 9
STATE & NAT'L. BD. REV., BASIC, April 16, CLINICAL, April 23
RADIATION ONCOLOGY, 5 days, April 23
GENERAL & DIAGNOSTIC RADIOLOGY, 5 days, April 23
SPECIALTY REVIEW OB-GYN, April 30
SPECIALTY REVIEW FAMILY PRACTICE, May 7
SPECIALTY REVIEW ANESTHESIOLOGY, May 13
REVIEW IN MEDICAL SUBSPECIALTIES, May 7, 14, 21

Information concerning numerous other continuation courses available upon request.

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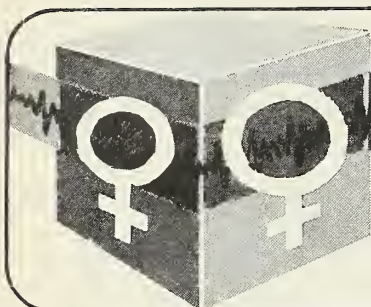
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pulse... of the ISMS auxiliary

MRS. EUGENE VICKERY, Editor



Growth Patterns

*They surfeited with honey and began
To Loathe the taste of sweetness, whereof a little
More than a little is by much too much.*

(King Henry the Fourth, Part One)

MRS. EARL V. KLAREN, PRESIDENT, ISMSA

Why is it that when life holds too many choices, the process of decision-making becomes more difficult? Such a situation can confuse and obscure matters of true concern to the individual. One can hold back from making lasting decisions—or any decisions—if there are limitless opportunities and the luxury of changing one's mind.

Recent history gives ample testimony to this. Far too many people are still trying to decide what they are going to be when they grow up. They have changed majors, schools and life-molding decisions with impunity, and are seemingly unaware of the passage of time. Most are intelligent and motivated, but highly dissatisfied. The past two decades of affluence seem to have been a mixed blessing, and the old adage holds true: there can definitely be too much of a good thing.

Perhaps with the help of this background one can better understand part of the problem in attracting young physician's spouses to auxiliary work. Their horizons have been without bounds, and their community opportunities are broader

now than they have ever been. They think they know what "auxiliary" is, and feel that they can always return to it when they have tasted and tested everything else to see if other organizations are "more satisfying."

The bright, aggressive hospital administrators of today know the value of latching onto these talented young workers early-on, and we lose their potential if we are not Johnny-on-the-spot as they arrive in our communities.

As a volunteer organization we are now faced with some frustrating limitations. Recruiting and retaining members is becoming an ever increasing problem cross-country. Over 15,000 members have been lost in recent years, and one can only conjecture as to the cause.

The rising cost of volunteering, antiorganizational trend, and fact that membership in county medical societies is not the requirement for hospital staff privileges it once was have been cited as factors.

The latter is clearly one reason for doctors'

spouses joining hospital auxiliaries before or in place of medical society auxiliaries today. The situation must be confronted, for it constitutes our greatest loss. Potential members must be convinced that bypassing this opportunity is a short-sighted decision.

Membership must be marketed and sold in a positive manner, just as other worthwhile modern concepts are brought to the attention of the people institutions wish to reach and interest.

DUAL BILLING would seem the best tool and greatest aid if we are going to continue to be a strong, supportive ancillary organization, and we need the help of the ISMS to achieve this goal.

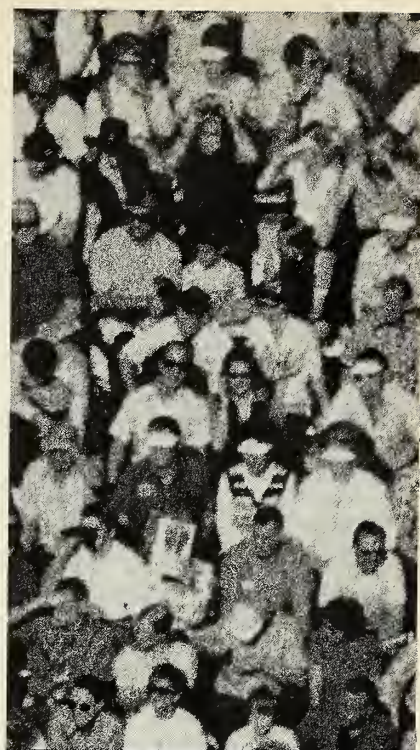
On the positive side it should be mentioned here that Illinois was one of the few states in the country to have a membership increase last year, and we have continued to grow with a new county, and new members. This, we believe, is the result of our many highly successful community service programs.

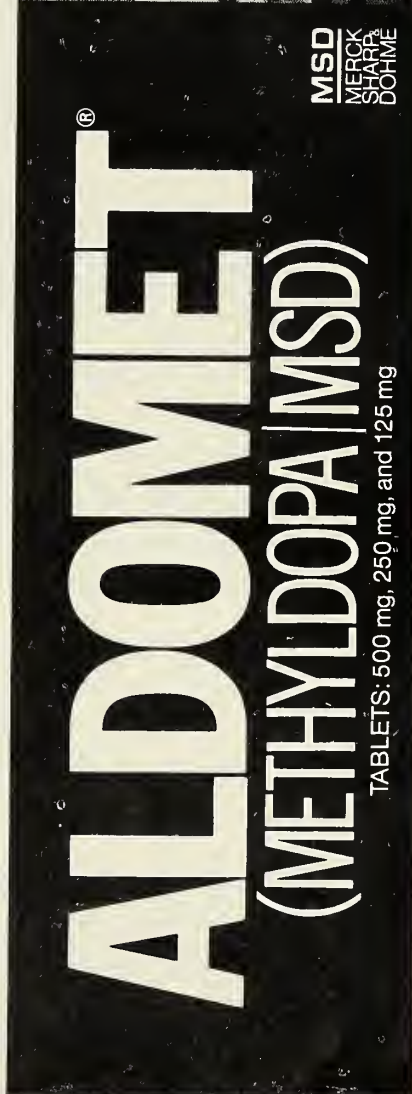
Our programs stem from a working knowledge of people and their problems at the community level. We are in a unique position to judge needs, and have ready tools at our disposal to help. Our projects are not based on unworkable theory or unreachable bureaucratic goals that leave the public frustrated and underserved.

We have something in Auxiliary that we believe to be of intrinsic worth and lasting value. We must convince newcomers to the medical community that their long-term interests will be better served within our organization. We cannot afford to fragment ourselves at this time. We must make them realize that they are the greater losers, for they have to go the distance in medicine regardless of the outcome, and their lives and work will suffer if medicine deteriorates in this country because of government intrusion. They cannot afford to spend time tasting and testing other organizations while government bureaucrats formulate rules and guidelines, which are really soft words for hard laws and unchangeable policies.

Perhaps with this in mind, we can sort out why so many newcomers to the medical community are not making what to us is the obvious choice: "join us, for we can all do more together."

"Teens and Drinking," will be the subject of a special program at the Cook County Medical Society Auxiliary Annual Luncheon scheduled for March 13, 1979, at the Chicago Ritz Carlton Hotel. Interested persons should contact Mrs. Morris Friedell, 180 E. Pearson, Apt. 5106, Chicago IL 60611, for further information.





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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ARCOLA: Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

ATKINSON: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

AURORA: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

CARBONDALE: G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

CHICAGO: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

FAIRFIELD: Population 6,500. Opening for OB-Gyn board eligible or certified and general practitioner to join group of two physicians (F.P. and surgeon). Complete office facilities, excellent salary and fringe benefits, opportunity to become full partner. Near university, junior college locally. Good fishing, hunting, cultural opportunities, all churches. Contact: S. W. Konarski, M.D., 401 East Center Street, Fairfield 62837. (618) 842-2187. (3)

HARVARD: An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

LA GRANGE: Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on

CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

LISLE: Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

MACOMB: GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

MATTOON: American trained family practitioner or internist for rewarding practice. Fully equipped office available—new 210 bed hospital (open staff)—financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient population of 75,000. Contact: A. Rauwolf, M.D., 1120 Wabash, Mattoon 61938. (217) 234-6253. (4)

PAXTON: Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387. (12)

PEORIA: Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

WEST FRANKFORT: Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMW Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)

You Couldn't Hold a Candle to the ISMS Interim Meeting

The ISMS House of Delegates Interim Meeting was held in Rockton on November fourth and fifth. As detailed in our December issue (IMJ 154:6, 413) many serious matters were debated at that meeting. Careful planning produced an organized, placid session—unless you're ruffled by a total power failure forcing reference committees to meet by candlelight and a minor explosion . . .

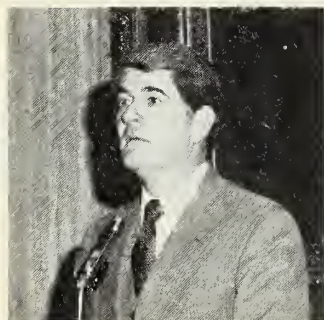


When members of the Board of Trustees convened on Friday, they were given a three-alarm greeting by volunteer firemen from the physician fire brigade, Drs. Seward, Perez and Green (1). The Interim Session promised to be a busy one, and was highlighted with guest appearances by Rep. Edward R. Madigan (2) and UI Trustee Edmund O'Donoghue, M.D. (3) Awards were given, including a special plaque honoring Eugene Balthazar, M.D., for his free clinic serving the Aurora community. (4)

The House of Delegates opened on Saturday, (5) and initiated serious deliberations. (6) Reference committees met to hear open debate on more than 60 resolutions affecting the future of medicine. Late that afternoon, an hour before sunset, delegates were confronted by a unique challenge . . . a nearby auto accident severed all electrical power for several hours.

Determined to complete the business before them, delegates were not daunted, although the situation looked dimmer by the minute. Reference Committee B elected (7) to meet in the garage entrance, where the last rays of sunlight could be used to best advantage. Rockton police have reported that they are still at large, charged with illegal parking.

Reference Committee C appeared to be imple-



(2)



(3)

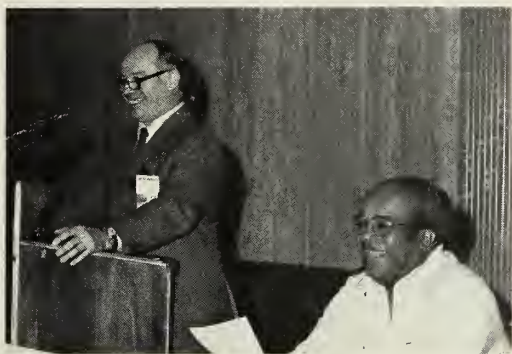


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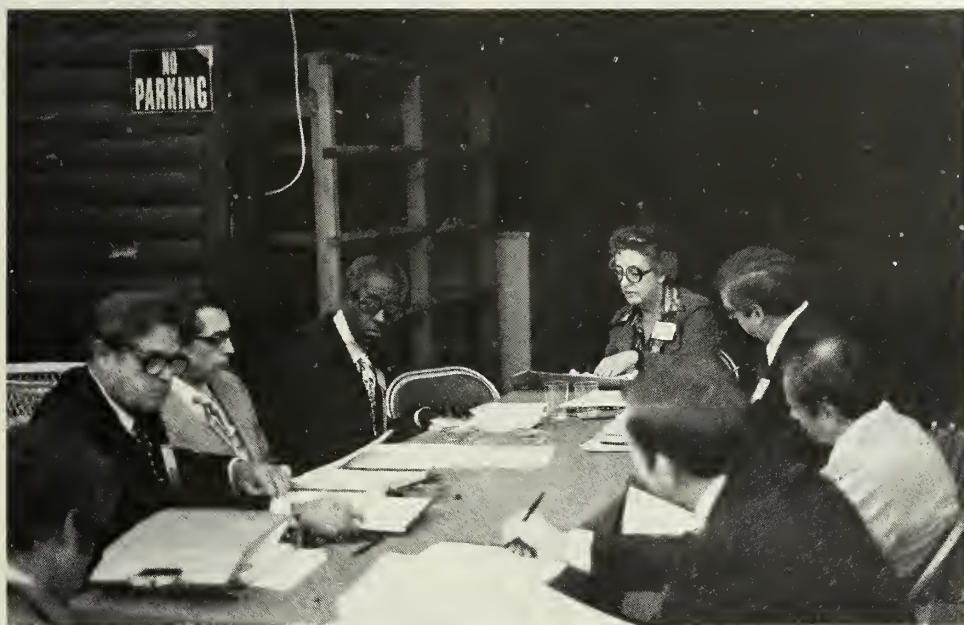
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menting their cost containment resolutions, (8) or perhaps holding a seance for Doctor SIMS. When last seen, Chairman J. M. Ingalls, M.D., appeared to be auctioning a priceless painting (9) in exchange for extra candles.

Meanwhile, Reference Committees A and D also chose to meet in the parking lot. One bystander was said to have commented that, historically, we may have witnessed the first known instance of executive session held "outdoors" (outside closed doors). Another observer opined that the members were preparing for a quick get-

(7)



(8)





(9)

away (10), least their decisions be met with disapproval.

Power was ultimately restored, of course, and the meeting proceeded calmly until Sunday afternoon, when a delivery van exploded in the parking lot. (11) (Some at first thought it only residual effects of smoke-filled rooms moved outside). The fire was contained without injury, although one fireman (12) was heard to comment, "Those volunteers are never around when you need them."



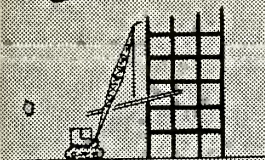
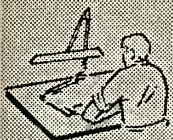
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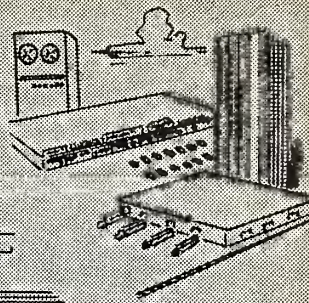
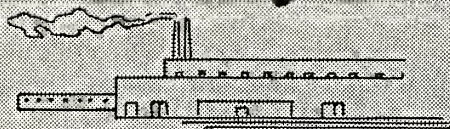
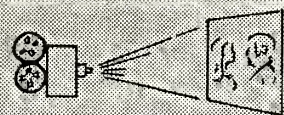
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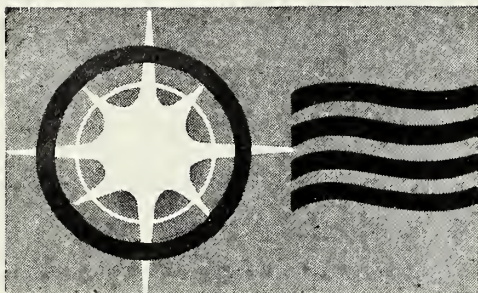
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Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

Mystery Resolved

To the Editor:

I was interested to read the article "How to Swim with Sharks: A Primer" published in the August, 1978, IMJ (154:2). The Editor's note indicates that there was a single note reading "Perspectives in Biology and Medicine, Summer, 1973". You asked for further information from anyone who could supply it. I am familiar with the article. The author of this article is Voltaire Cousteau and the article did appear in the journal "Perspectives in Biology and Medicine" in the summer of 1973.

The article which you published is a virtual reproduction of the original article. My first exposure to the article came through an adaptation done by L. Thomas Wolff, M.D., the Director of the Residency in Family Practice at St. Joseph's Hospital Health Center in Syracuse, New York, a teaching affiliate of the S.U.N.Y. Upstate Medical Center. He has adapted the article to the problems facing persons involved in the development of Family Practice residencies. His is an amusing, as well as an informative lecture when accompanied by some clever cartoon slides which Dr. Wolff developed.

Unfortunately, I have no copies of the cartoons. I do however, have a copy of his talk as given at the Family Practice Seminar in 1976, in Kansas City. I enclose the talk for your information.

I hope this information will be helpful to you.

Sincerely yours,

Charles T. McHugh, M.D.
Vice President, Medical Education
Columbus/Cuneo/Cabrini
Medical Center
Chicago

A Confirmation

To the Editor:

"How to Swim With Sharks: A Primer" appearing in Volume 154, No. 2, August 1978 of the Illinois Medical Journal appeared in Perspective of Biology & Medicine Summer 1973 and was written by Voltaire Cousteau.

"Little is known about the author, who died in Paris in 1812. He may have been a descendant of Francois Voltaire and an ancestor of Jacques Cousteau. Apparently this essay was written for sponge divers. Because it may have broader implications, it was translated from the French by Richard J. Johns, an obscure French scholar and Massey Professor and director of the De-

partment of Biomedical Engineering, The Johns Hopkins University and Hospital, 720 Rutland Avenue, Baltimore, Maryland, 21205."

I regularly give this to my resident and students as a guide to rounds, as a present from Mike Cashman.

Sincerely yours,
Jack Domnitz, M.D.
Peoria

Critical Comments

To the Editor:

This refers to the article "Bedside Barium Enema," Volume 154, #1, July, 1978. The article, in my opinion, promotes an unsound medical principle. To state that a bedside barium enema could be of both diagnostic and therapeutic benefit on the basis of two cases lacks validity on a statistical basis.

I believe a bedside barium enema even in the emergency-type situation described would seldom be of any benefit. I believe the finding of diverticula presented in this case is not very useful clinical information in making a diagnosis. I question the therapeutic effect described.

Sincerely,
P. F. Mahon, M.D.
Springfield

To the Editor:

On reviewing the July issue of the Illinois Medical Journal, I think that the article "Bedside Barium Enema," is rather poorly done and some of the conclusions are not medically correct.

Constantine S. Soter, M.D.
Arlington Heights

Cancer and the Clinician

We are making good progress in the fight against cancer of the female organs. The cancers of the breasts and cervix are detected earlier and the survival rate is improving. But remarkably, not a breakthrough in diagnosis and treatment is responsible for the success. It is rather the sexual revolution. A few decades ago, it was not easy to get a woman to the office for an examination. It was frowned upon by many cultures the world over. Today, due to sexual freedom and enlightenment, even teenagers come freely for examination and advice. The most reluctant patient is probably grandmother

from the old country. The natural outlook toward health is reflected in our culture. We can read about the anatomy, function of the female organs, self-testing and cancer almost daily in newspapers and magazines. Women's clubs have programs on the subject. The radio reports on abortion. Childbirth and examination of barebreasted women can be seen on the TV screen. This was unthinkable even a decade ago. The shattering of the cultural taboo is the biggest single factor in early discovery of the female cancer.

The fight against cancer of other organs is not so fortunate, take the colo-rectal cancer for instance. This is perhaps more common than any other. It appears to be present in precancerous polyps for years. And our diagnostic technics are sophisticated enough to discover them early. Yet most of them are discovered in a highly symptomatic state with a dismal 40-45% five year survival. Where do we fail?

Part of the blame must be placed on the profession. While we do almost too much screening for cancer of the lung and the female organs,

our record for screening tests for cancer of the colon is definitely poor.

The biggest factor of our failure is in our cultural environment. In asymptomatic patients, rectal examination is not done enough. Many patients refuse it unless they are in distress. The physician is often helpless dispelling prejudices. Expense, inconvenience, discomfort of enemas and embarrassment are all contributing factors. A cultural taboo still cloaks the rectum and prevents many patients seeking a preventive rectal examination. We can hardly find an article in the lay press about the necessity of the rectal examination. It is not in good taste to discuss the symptoms on the air or demonstrate the rectal examination on the screen of the six o'clock news. The colo-rectal surgeon views with envy the publicity and public awareness of the female cancer. We know how to discover early and how to treat cancer of the colon and rectum. But how do we fight the cultural taboo?

James Scott, M.D.
Streator

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

FEBRUARY

Anesthesia

ANESTHESIA REVIEW AND UPDATE

For: MD's, nurses, Anesthesiologists. 1-day course, Feb. 24, 8:00 a.m.-5:00 p.m., Chicago. Speaker: John B. Stetson, MD. Sponsor: Rush-Presbyterian-St. Luke's Medical Center, Rush Medical College, Dept. of Anesthesiology, Dept. of Continuing Education, 600 So. Paulina St., Chicago, IL 60612. Fee: \$55. Credit: AMA Category 1, 8 hours. Contact: Lindy Ellis. Phone: 312-942-3497.

Family Medicine

COMMUNICABLE DISEASE AND IMMUNIZATIONS

For: MD's. Lecture, Feb. 21, 2:00 p.m., Country Club in DuPage County. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Widmer.

General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA

For: MD's. 1-day lecture, Feb. 6, 8:00-10:00 p.m., Michael Reese Hospital, Chicago. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Husa.

Musculoskeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA

For: MD's. Lecture, Feb. 13, 8:00-10:00 p.m., Ingalls Hospital, Harvey, IL. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Reg. limit: none. Fee: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Husa.

Psychiatry

IN SEARCH OF THE BORDERLINE: THE CURRENT LIMITS OF PSYCHOANALYSIS AS A THERAPY

For: Mental health professionals. Lecture, Feb. 21, 8:00 p.m., Offield Auditorium, Passavant Pavilion, Chicago. Sponsor: Institute of Psychiatry, 320 E. Huron St., Chicago, IL 60611. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1½ hours. Contact: Leon Diamond, MD. Phone: 312-649-8058.

Psychiatry

SYSTEMS AND STRATEGIES IN FAMILY THERAPY

For: Psychiatrists. Lecture, Feb. 21, 1:00-4:00 p.m., Forest Park. Speaker: Peggy Papp, ACSW. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Fee: \$15. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312-771-7000.

Surgery

SPECIALTY REVIEW COURSE IN THORACIC SURGERY

For: General and Cardiothoracic Surgeons. 6-day lecture, Feb. 13, Chicago. Speaker: Sidney Levitsky, MD. Sponsor: Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 200. Credit: AMA Category 1, 48 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

MARCH

Cardiology

CARDIAC EMERGENCIES

For: MD's, other health professionals. Symposium, March 29, 1:00-5:00 p.m., Litchfield, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Cardiology

INTENSIVE CARE CARDIOLOGY

For: MD's. Symposium, March 21, 1:00-5:00 p.m., Marion, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Family Therapy

SIXTH ANNUAL SPRING CONFERENCE: TREATMENT OF MARITAL COUPLES

For: Psychiatrists, Therapists. 2-day conference, March 30-31, Continental Plaza Hotel, Chicago. Speaker: Clifford Sager, MD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Credit: AMA Category 1, 12 hours. Contact: Wendy Brockington. Phone: 312-649-7285.

Gastroenterology

NEW DEVELOPMENTS IN INFLAMMATION BOWEL DISEASE

For: GP's. Lecture, March 14, 1:30-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. Fee: \$20. Reg. limit: none. Credit: AAFP Elective, 3 hours; AMA Category 1, 3 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Gastroenterology

MANAGEMENT OF DIGESTIVE DISORDERS

For: MD's. 3-day course, March 27-29, 8:00 a.m.-5:00 p.m., Center for Continuing Education, 1307 E. 60th St., Chicago. Sponsor: University of Chicago Section of Gastroenterology and Liver Study Unit, Box 400, 950 E. 59th St., Chicago, IL 60637. Fee: \$240. Reg. limit: 225. Credit: AMA Category 1, 22 hours. Contact: Sumner Kraft, MD. Phone: 312-947-5567.

Internal Medicine

INTERNAL MEDICINE BOARD EXAMINATION REVIEW

For: MD's. Weekly lectures, March-May, Monday evenings, St. Louis, Missouri. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 175. Credit: AAFP Elective, 36 hours; AMA Category 1, 36 hours. Contact: Loretta Giacometto. Phone: 314-454-3873.

Internal Medicine

AN UPDATE IN RENAL DISEASES

For: MD's. Symposium, March 1-2, St. Louis, Missouri. Sponsor: Washington University School of Medicine, Continuing Medical Education, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. Fee: \$120. Reg. limit: 150. Credit: AAFP Elective, 12 hours; AMA Category 1, 12 hours. Contact: Loretta Giacometto. Phone: 314-454-3873.

OB/GYN

OFFICE GYNECOLOGY AND UROLOGY SYMPOSIUM

For: MD's, nurses. Symposium, March 8, 1:00-5:00 p.m., Pittsfield, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

ADJUNCTIVE CANCER THERAPY

For: MD's. Symposium, March 1, 7:00-10:00 p.m., Mt. Vernon, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

G I MALIGNANCY SYMPOSIUM

For: MD's. Symposium, March. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

DERMATOLOGY SYMPOSIUM

For: MD's. Symposium, March 17, 3:00-9:00 p.m., Flora, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Fee: \$25 pre. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Musculoskeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA

For: MD's. Lecture, March 20, Community Memorial General Hospital, LaGrange, IL. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Husa.

Pediatrics

PEDIATRIC NEUROLOGY

For: Pediatricians, FP's, GP's. Symposium, March 29-30, St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Cosponsors: Div. of Pediatric Neurology, Dept. of Pediatrics, Fee: \$120. Reg. limit: 150. Credit: AMA Category 1, 12 hours; AAFP Elective, 12 hours. Contact: Loretta Giacometto. Phone: 314-367-9673.

Primary Care

CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION

For: GP's, Internists. Lectures/workshops, March 16-18, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Psychiatry

FAMILY THERAPY: STATE OF THE ART AND THE SCIENCE

For: Mental health professionals. Lecture, March 21, 8:00 p.m., Offield Auditorium, Passavant Pavilion, Chicago. Speaker: Charles Kramer, MD. Sponsor: Institute of Psychiatry, 320 E. Huron St., Chicago, IL 60611. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1½ hours. Contact: Leon Diamond, MD. Phone: 312-649-8058.

Surgery

THE ACUTELY INJURED HAND

For: MD's, nurses. Symposium, March 16, 8:00 a.m.-5:00 p.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Surgery

MICRO-NEURORRHAPHY COURSE SYMPOSIUM

For: MD's Workshop, March 12-15, 8:00 a.m.-2:00 p.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Reg. limit: 18. Credit: AMA Category 1, 22 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

APRIL

Child Psychiatry

DEVELOPMENTAL DEVIATIONS IN CHILDREN AND ADOLESCENTS

For: MD's, social workers. Symposium, April 23-24, St. Louis, MO. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$90. Reg. limit: 150. Credit: AMA Category 1, 9 hours. Contact: Loretta Giacometto. Phone: 314-454-3873.

Continuing Medical Education

1979 ANNUAL CONGRESS ON CME

For: MD's, DME's, program chairmen. April 6-7, Oak Brook Hyatt House, Oak Brook, IL. Sponsor: Illinois Council on CME, 55 E. Monroe St., Suite 3510, Chicago, IL 60603. Fee: \$60 (ISMS members). Credit: AMA Category 2, 9 hours. Contact: Diane Wolniewicz. Phone: 312-236-6110.

Family Medicine

FAMILY PRACTICE REVIEW

For: FP's. Symposium, April 16-20, Ann Arbor, MI. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, MI 48109. Fee: \$275. Reg. limit: 350. Credit: AMA Category 1, 36¾ hours; AAFP Prescribed, 36¾ hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Family Medicine

OBESITY

For: GP's. Lecture, April 11, 2:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. Fee: \$20. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Eloise Ehrman. Phone: 312-947-5777.

Forensic Medicine

REVIEW OF CURRENT FORENSIC PATHOLOGY CASES

For: MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, IL, 1828 W. Polk St., Chicago, IL 60612. Fee: none. Reg. limit: 50. Contact: Robert Stein, MD. Phone: 312-443-5017.

General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA

For: MD's. Lecture, April 3, 8:00-10:00 p.m., Ingalls Hospital, Harvey, IL. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Reg. limit: none. Fee: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Huso.

Internal Medicine

RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF THE HYPERLIPIDEMIAS

For: MD's, dietitians. Symposium, April 19-20, St. Louis, MO. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$120. Reg. limit: 150. Credit: AMA Category 1, 12 hours; AAFP Elective, 12 hours. Contact: Loretta Giacometto. Phone: 314-454-3873.

Internal Medicine

ADVANCES IN THE THERAPEUTICS OF INTERNAL MEDICINE

For: MD's. Course, April 25-27, Lexington, KY. Sponsor: American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. Cosponsor: Univ. of Kentucky School of Medicine. Reg. deadline: 4/11. Fee: \$180/240/90. Reg. limit: 200. Credit: AMA Category 1. Contact: Linda Salsinger. Phone: 215-243-1200.

Internal Medicine

MIDWESTERN STUDY CONFERENCE

For: GP's, Internists. Lectures, April 26-28, 8:00 a.m.-2:00 p.m., Sheraton Plaza Hotel, Chicago. Sponsor: Chicago College of Osteopathic Medicine, 5206 S. University, Chicago, IL 60615. Cosponsor: American College of Osteopathic Internists. Fee: \$125. Reg. limit: none. Credit: AOA, 20 hours. Contact: Marie Kowolsky. Phone: 312-947-4606.

Musculoskeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA

For: MD's. Lecture, April 17, 8:00-10:00 p.m., Grant Hospital, Chicago. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Reg. limit: none. Fee: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Huso.

OB/GYN

SIXTH ANNUAL SYMPOSIUM ON OBSTETRICS AND GYNECOLOGY

For: MD's. Symposium, April 26-27, St. Louis, MO. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$120. Reg. limit: 150. Credit: AMA Category 1, 12 hours; AAFP Elective, 12 hours. Contact: Loretta Giacometto. Phone: 314-454-3873.

Psychiatry

WHAT IS BIOLOGICAL ABOUT PSYCHIATRY?

For: Mental health professionals. Lecture, April 18, 8:00 p.m., Offield Auditorium, Passavant Pavilion, Chicago. Speaker: Daniel X. Freedman, MD. Sponsor: Institute of Psychiatry, 320 E. Huron St., Chicago, IL 60611. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1½ hours. Contact: Leon Diamond, MD. Phone: 312-649-8058.

Pulmonary Pathology

PULMONARY PATHOLOGY

For: Pathologists, Chest Physicians. 4-day course, April 25-28, Playboy Towers, Chicago. Speaker: William M. Thurlbeck, MD. Sponsor: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068. Fee: \$185/200. Credit: AMA Category 1, 25½ hours. Contact: Mary Ellen Zielinski. Phone: 312-698-2200.

SAVE THE DATE

1979 ANNUAL CONGRESS ON CME

April 6-7

Oak Brook Hyatt House

"Planning a CME Program that Works—
What to Present,
Checking for Effectiveness"

RECENT CME ACCREDITATION RECOMMENDATIONS

The ISMS Committee on CME Accreditation has recommended to the Liaison Committee/CME approval of the CME programs of the following institutions:

Champaign County Medical Society, Urbana

Chicago Neurological Society

Hinsdale Sanitarium and Hospital

Illinois Society of Ophthalmology and Otolaryngology, Danville

Lutheran Hospital, Moline

Rock Island Franciscan Medical Center

St. Mary's Hospital, Kankakee

St. Therese Hospital, Waukegan

Sherman Hospital, Elgin

South Shore Hospital, Chicago

Victory Memorial Hospital, Waukegan

Wood River Township Hospital

INCREASE IN CME ACCREDITATION FEES

Due to rising administrative costs, the ISMS Board of Trustees has approved a new fee structure for Illinois CME sponsors seeking accreditation status. The following fees are effective as of January 1, 1979:

Registration fee \$100
(waived for ISMS component societies)

Accreditation survey fee for medical organizations with 49 or fewer members \$300
All other CME sponsors \$450



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Our administrative plan for the Illinois Medicare program is to assure prompt and accurate payment of claims for medical services furnished to Medicare beneficiaries.

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- Prompt and Accurate Claims Processing
- Professional Relations Assistance
- Medicare Information and Claim Filing Handbook
- Medicare Workshops
- Data Processing Technical Assistance
- Paperless Tape-to-Tape Bill Processing
- Mail and Telephone Communications

With emphasis on Claims Administration, Quality of Care and Professional Relations, we are dedicated to utilizing our experience and resources to provide Illinois physicians and Medicare beneficiaries prompt and accurate service. Future issues of the Illinois Medical Journal will contain more information concerning our administration of Part B Medicare. In addition, newsletters and other informational material will be mailed directly to all physicians participating in the Medicare program.

We look forward to an enjoyable working relationship with Illinois physicians in a cooperative effort to serve the Medicare beneficiaries.

E.D.S. Federal Corporation

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ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

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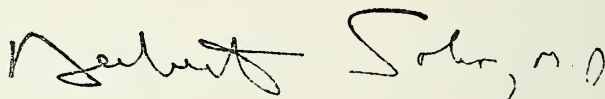
Dear Colleague:

January is traditionally the month of "new beginnings". New Years resolutions are made and at least for the first few days faithfully kept. Holiday feasts are dutifully exercised and dieted away. But by the time February and March roll around, many of us have forgotten all of our good intentions.

This same phenomenon seems to occur each year when doctors begin to pay IMPAC membership dues. In January, many regularly add their IMPAC contribution to their ISMS membership dues payment. Some don't, promising themselves that they will mail the check in separately. But by March, many have simply forgotten their resolve to join medicine's political action arm.

Last year, IMPAC enjoyed a good year. Membership was approximately 50% of all ISMS members. But we cannot rest -- one out of every two physicians still has not received our message. I firmly intend to find out why. And I ask your help. Is there some reason you or one of your medical colleagues hasn't joined our efforts? If there is, please tear this column out of your Illinois Medical Journal; write me a brief note explaining your reasons. I'd appreciate hearing from you.

Sincerely,



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



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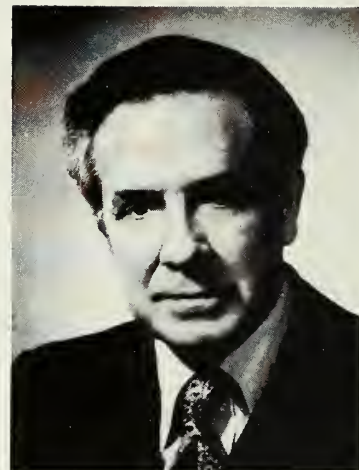
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President's Page

The NHI Debate

A Victory . . . But What Next?



The AMA will not submit an NHI bill to Congress. In an unexpected turnaround, the AMA House last month directed the Association's leadership to stop promoting a comprehensive NHI proposal. The action was a major victory for ISMS which doggedly opposed the AMA strategy.

Debate over introduction of a new bill—The Health Insurance Improvement Act of 1979—actually focused on these questions:

- Can the push for NHI be turned back . . . or is NHI inevitable?
- Should we (AMA) commit our energies and resources to a hardline stand against NHI . . . or should we participate in NHI planning, hoping to grasp for the profession the best part of a bad bargain?

The state of the nation's economy and monumental federal deficit have formed a dark cloud over the drive to enact NHI. President Carter has acknowledged that—despite campaign promises—this country cannot afford NHI. That fact—coupled with the highly-publicized Carter-Kennedy split on the issue—lead many delegates to

conclude that it can no longer be stated with any certainty that NHI is inevitable.

Delegates were confronted with a dilemma that did not surface in earlier NHI debates: What would our position be if Sen. Kennedy—now facing a bitter struggle—embraced the AMA-backed bill as the best available? Obviously, many concluded that such action would place the profession in an untenable position. Lost would be our strategic advantage of being able to oppose at least portions of an NHI bill. Simply stated, we would be working for enactment of NHI, not—as some have maintained—for “a seat at the NHI bargaining table.”

The Illinois delegation unanimously opposed the AMA leadership's strategy of introducing an NHI bill. For now, we can claim victory. It would be fool-hardy to assume, however, that the NHI battle within organized medicine is over. The AMA meeting produced a satisfying, but unexpected, shift in position. What will happen at the Association's annual session this summer is anyone's guess. ◀

A handwritten signature in dark ink, reading "David S. Fox".

David S. Fox, M.D., President

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EMERGENCY DEPARTMENT DIRECTOR, immense experience, trouble-shooter, seeking relocation central, eastern, upstate, Illinois. Proven track record in growth and stabilization. ACEP. Private negotiations with administrator, no agents. Available mid-79. Box 941, c/o Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago, Illinois 60603.

MISCELLANEOUS

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FOR SALE: Illinois Medical Malpractice Certificate. Amount: \$772.00. Contact: First National Bank, Altan, IL 62002, Trust Department, Area Code 618-463-2253. Re: Donald Bottom Estate.

FOR SALE—Guaranty Fund Certificate with Illinois State Medical Society. Value \$10,680.00. Call (312) 498-5322.

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Encounters of the Learning Kind

Saturday, February 3, 1979, Holiday Inn East, Springfield

Sunday, March 4, 1979, LaSalle Howard Johnson's, Peru

8:30 a.m. to 3:30 p.m.

Morning Session

Registration—Coffee, tea, and rolls. Compliments of Gil Stawick Gilberts Surgical Supplies

Improving Office Collections: Mr. Morton Hoffman, Vice Pres., Illinois Collectors Assn.

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Wisconsin Physicians Service: Mr. James Berry and Mr. David Schuller, Field Service Reps.

Noon Luncheon: Ideas for regional meetings

Afternoon Session

Emergencies in The Medical Office: Speakers furnished by the Illinois Academy of Family Physicians

IDPA Update: Mr. John Robertson, Provider Service Section Supervisor Illinois Department of Public Aid.

Application has been filed with the AAMA to award CEU credits for this program. For further information, please contact Vivian Kraft, CMA, c/o John L. Wright, M.D., 2416 E. Washington, Suite A, Bloomington, 61701, (309) 662-1703. For reservations, please detach the coupon below and return to Mary Lu Ostrowski, CMA, 1704 E. Jackson St., Bloomington, 61701, (309) 828-4504.

Travel Course: February 3, Springfield___March 4, Peru___

Registration fee is \$8.00 for members and \$10.00 for non-members

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Illinois Medical Journal

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Clinics for Crippled Children Listed for March

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 24 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- March 1 Sterling—Community General Hospital
- March 1 Effingham—St. Anthony Memorial Hospital
- March 2 Division Cardiac—U. of I. at the Medical Center
- March 6 Carrollton—Boyd Memorial Hospital
- March 6 Belleville—St. Elizabeth's Hospital
- March 6 Park Ridge Cardiac—Lutheran General Hospital
- March 7 Hinsdale—Hinsdale Sanitarium
- March 7 Carmi—Carmi Township Hospital
- March 8 Springfield General—St. John's Hospital
- March 8 Lake County Cardiac—Victory Memorial Hospital
- March 8 Macomb—McDonough District Hospital
- March 9 Chicago Heights Cardiac—St. James Hospital
- March 12 Peoria Cardiac—St. Francis Hospital
- March 13 Peoria General—St. Francis Hospital
- March 14 Champaign-Urbana—McKinley Hospital
- March 14 Centralia—St. Mary's Hospital
- March 14 Joliet—St. Joseph's Hospital
- March 14 Chicago Heights General—St. James Hospital
- March 14 Rockford—St. Anthony's Hospital
- March 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- March 16 Kankakee Cardiac—St. Mary's Hospital
- March 19 Maywood—Loyola Medical Center
- March 20 Alton—Alton Memorial Hospital
- March 20 Decatur—Decatur Memorial Hospital
- March 20 Rock Island General—Moline Public Hospital
- March 21 Springfield Ped-Neuro—St. John's Hospital
- March 21 Elgin—Sherman Hospital
- March 21 Evergreen Park—Little Company of Mary Hospital
- March 22 West Frankfort—Union Hospital
- March 23 Chicago Heights Cardiac—St. James Hospital
- March 26 Peoria Cardiac—St. Francis Hospital
- March 27 East St. Louis—Christian Welfare Hospital
- March 27 Peoria General—St. Francis Hospital
- March 28 Chicago Heights General—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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Editorials



Oral Health in Pregnancy

Prenatal care has progressed in many ways since the days of the quick blood pressure and weight check, cursory abdominal examination and occasional listen to the fetal heart. Today's obstetrician is interested in such aspects of fetal and maternal well being as proper nutrition and exercise, scientific screening of all patients for previously unsuspected metabolic abnormalities, and patient education and psychological preparation for childbirth. Genetic counseling and antenatal diagnosis of many abnormalities are now commonplace. The physician is also aware of the unfavorable influences of alcohol, tobacco, and many other drugs, and is able to advise his patients regarding these and other outside influences which may have an adverse effect on the outcome of pregnancy.

One area of total health care that often has been somewhat neglected until recently is dental health. Many may remember the day when it was said that a mother must lose a tooth for every pregnancy. Obviously, such is not the case. The teeth of the pregnant patient should not be overlooked in our continuing effort to conclude every pregnancy with a healthy mother and a healthy baby.

In this issue of the *Journal*, Poma and his co-workers have shown that the dental health of the pregnant patient can be protected when it is good, and corrected when unsatisfactory. Their study

was conducted on patients at Cook County Hospital, undoubtedly including many with poor nutrition, little previous health care, and minimal education. Twenty-two hundred pregnant women were included in the study group, representing all stages of pregnancy. Most of the patients had pathology in the oral cavity and limited knowledge of dental health. The authors were able to demonstrate that prophylaxis and treatment were possible and that results were rewarding. Modern technology makes it possible to treat oral disease during pregnancy without fear of fetal harm. Such treatment can only be helpful as it can directly affect improved nutrition and eliminate one site of chronic low grade infection.

Unfortunately, most of the studies and reports of dental disease in pregnancy have appeared in the dental literature. Thus, those physicians directly responsible for the primary care of pregnant patients have not had the opportunity to become familiar with what has been done in the past and what can be done in the future. Poma, *et. al.*, have reminded us to go a bit further in our consideration of the whole patient and to use prenatal visits as a forum to educate our patients about their dental needs, to make professional dental care and prophylaxis available to pregnant women, and to ensure that all gravidas are enrolled in a long term follow-up dental program. ◀

J. W. RODDICK, JR., M.D./SPRINGFIELD
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As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, a new Illinois state law makes it more difficult to exercise this right. Unless you sign your prescriptions on the bottom line of your new prescription pads, the pharmacist is permitted to substitute another drug for your brand-name prescription.

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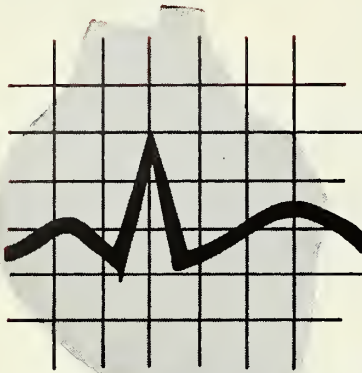
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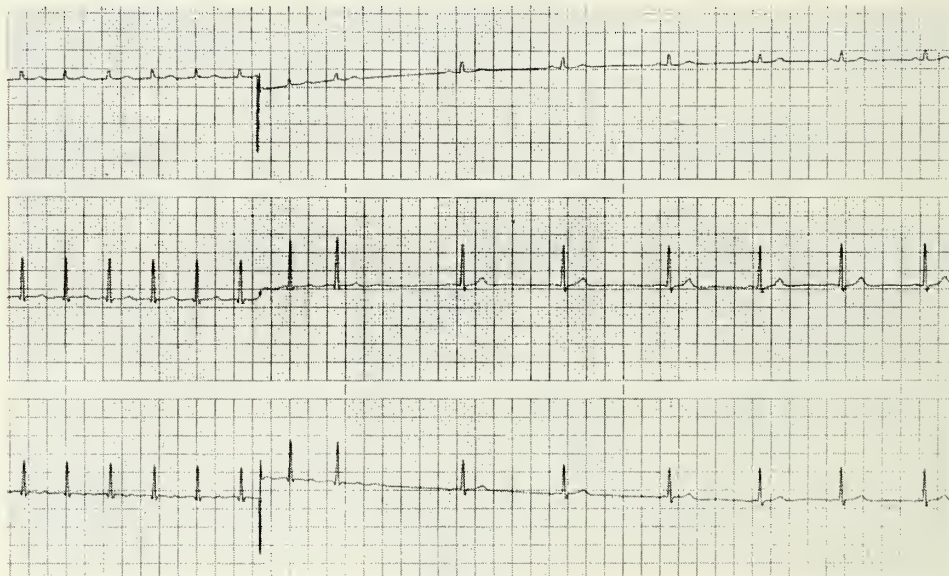
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

The patient was a 26-year-old lady who works as a secretary. She was in good health except for periodic palpitations which seemed to be coming more frequently. Six months ago, these palpitations would come every other week or so and last a few minutes. Lately, they had occurred two or three times per week and lasted up to an hour. Palpitations were not associated with chest pains, light-headedness or other symptoms. Her physical examination was normal except for a mid-systolic click and a grade 3/6 late systolic murmur. While in the office, she developed the palpitations. The simultaneous lead I, II, III ECG rhythm strip was taken. The break in the line after the 7th beat is an artifact.



Questions:

1. The ECG shows:

- A. Paroxysmal atrial flutter.
- B. Paroxysmal atrial fibrillation.
- C. Paroxysmal supraventricular or reciprocating tachycardia.
- D. Left ventricular hypertrophy.
- E. None of the above.

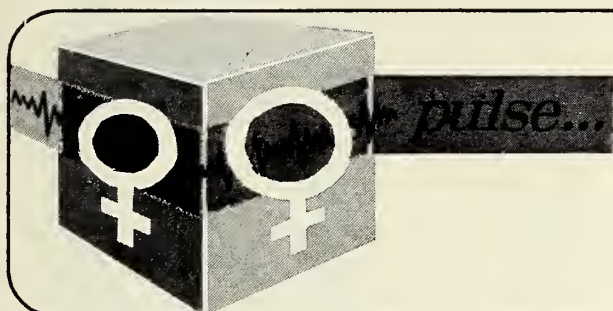
2. The following statement(s) is/are true:

- A. Cardiac arrhythmias and mitral valve pro-

lapse are commonly associated.

- B. The term mid-systolic click, late systolic murmur syndrome, billowing mitral leaflet syndrome, mitral valve prolapse, and Barlow's syndrome refer to the same entity.
- C. Sudden death occurs in these patients but is uncommon.
- D. The echocardiogram is useful in demonstrating the mitral valve prolapse.
- E. All of the above.

(Continued on page 134)



of the ISMS auxiliary

MRS. EUGENE VICKERY, Editor

Growth Patterns



MRS. EARL V. KLAREN, PRESIDENT, ISMSA

For more than 25 years, the American Medical Association Auxiliary has had one major fund-raising venture—to support AMA-Education and Research Foundation in its programs; to help further medical education; to provide financial assistance to medical students and residents; and to foster scientific and medical research. Donations are allocated by the contributor for two main purposes—Funds to Medical Schools; and Medical Education Loan Guarantee Program.

AMA-ERF—A “Mutual” Fund

“DURING THE FIRST NINE MONTHS OF 1978 THE AMA EDUCATION AND RESEARCH FOUNDATION GUARANTEED MORE THAN \$4 MILLION IN NEW LOANS FOR MEDICAL STUDENTS AND PHYSICIANS-IN-TRAINING IN RESIDENCY PROGRAMS.”

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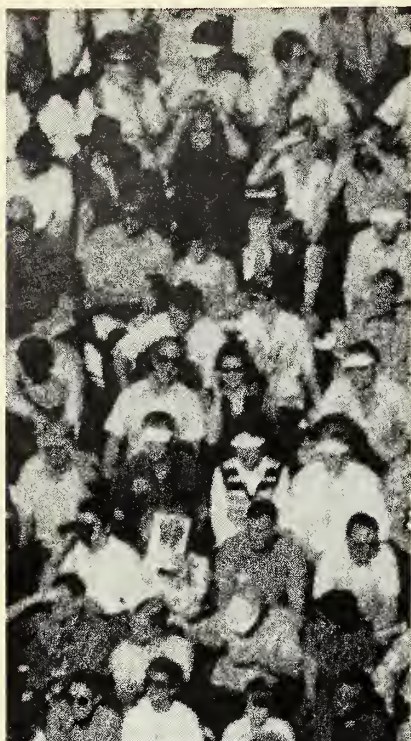
“MEDICAL ASSISTANT GRANT IS APPROVED.”

“AMA-ERF BACKS HOME HEALTH UNIT.”

ISMS and ISMSA should look with pride at such copy because they play such a big part in this very worthwhile and important project. (The quoted statements are taken from recent issues

of AM NEWS.) Not only does 'ERF provide a beautiful opportunity for positive image-building for the medical profession, but it answers a very pressing need to provide funds to further medical education and research projects. A grand total of \$1,577,372.53 was raised in 1977 and Illinois contributed a whopping \$171,248.65! (Totals not yet complete for 1978).

A new year is a good time to reaffirm commitments—especially with the cost of medical education soaring over 32% during the past two years. Average cost of room, board, fees and tuition will total \$4,393 for state residents at a public college; out-of-staters will pay an average of \$6,274; and for the private schools, average costs will total \$9,279. Keep in mind that this is for one year. Multiply by four and then imagine a freshman medical student facing a possible cost of over \$37,000. Obviously, help is needed



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desperately, especially since 56% of medical students come from families earning \$15,000 (or less) annually.

Loan funds available to medical students have become more and more difficult to find and more expensive for the students. Consequently, the 'ERF Loan Fund, which was designed as a "last resort" program, has been in greater demand. In fact, although contributions more than tripled during fiscal year '77 and 'ERF received over \$258,000, (translated into money to lend that equals \$3,225,000) the success of the program is threatening to overwhelm the accumulated resources. Annual contributions have not been keeping pace with the escalating number of students in need of assistance. (This year some safeguards have been built in to avoid financial distress.)

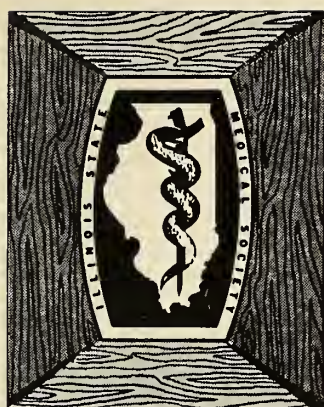
Participating banks commit \$12.50 for every \$1 in the AMA-ERF Loan Program. In other words, \$100 in the fund makes a \$1250.00 loan possible. This also means that the fund must have \$1 to cover each \$12.50 in the \$45,000,000 in loans outstanding. It is important to realize that participating banks actually make the loans in consideration of AMA-ERF's 100% written guarantee to repay any defaulted loan in full, including interest due. High finance, yes, but medical schools need financial help, students and residents are searching for monetary aid and you can get \$12.50 worth of loan for just \$1.00 when contributing to the Loan Guarantee Fund.

Ask your AMA-ERF Chairman about using 'ERF Promotional Materials for special "Thank You," "In Memoriam," "Physician Courtesy," "Thinking of You," and "In Honor Of." Get into the habit of using this method to raise tax deductible contributions. These attractive cards reflect your thoughtfulness, not only to the individual receiving it, but the medical schools and students benefiting from your gift.

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Mrs. Edward (Betty) Szewczyk
North Central Regional
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I M J

Illinois Medical Journal

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Oral Cavity Evaluation A Part of Prenatal Care

BY PEDRO A. POMA, M.D., C. V. ZAJDZINSKI, D.D.S., NASIRUDDIN RANA, M.D.,
LONNIE C. EDWARDS, M.D., AUGUSTA WEBSTER, M.D., AND
ROBERT C. STEPTO, M.D./CHICAGO

Complete evaluation of a woman during the prenatal period must include study of the oral cavity. Prenatal care includes prophylaxis and diagnosis of complications. Health education, especially as pertinent to nutrition, is emphasized.

In our prenatal services at Cook County Hospital, oral examination by a dentist was initiated in October, 1973. By May of 1975, 2,200 examinations had been completed. We reported these findings in relation to the age of the patient. The incidence of missing teeth and carious teeth increased with age. At the third decade of life, dental extractions were indicated in more than 50% of these cases. Periodontal disease was found in more than 90% of women older than age 20.

This study found that the information about dental health and prophylaxis among our patients is very scanty. The prenatal period may offer a receptive person available for education about her health and the health of the new generation. Many times obstetrical care is the only contact with the health system for women. This study points to another area where the obstetrician acting as primary care physician may help to improve the total health of the woman.

Prenatal care is becoming more accepted. The volume of patients attending our services is increasing. According to the National Center for Health Statistics, during 1975 in Illinois 70.5% of women began prenatal care in the first trimester of pregnancy. This is probably because of

an intense educational effort directed toward the public, and perhaps because there are observed benefits. The Chicago Board of Health offers free services to the pregnant woman, and many Chicago hospitals have prenatal clinics. This, also, may contribute to the smaller number of par-

turients admitted to the hospitals without prenatal care.

The obstetrician is the primary physician for the pregnant woman and her fetus. The aim of prenatal care is early detection of any disease, health education, counselling and prophylaxis of complications.

The initial visit includes a general physical examination. Oral cavity examination should be part of a complete physical examination. It was our impression that the incidence of oral cavity pathology was very high among our patients. Therefore, on July 13, 1973, a dental service was started in our prenatal services at Cook County Hospital, Chicago. We would like to report our preliminary findings.

Material and Methods

A dental chair and accessory equipment for diagnosis were placed in one of our consultation booths. Later, construction in the area helped alleviate the ensuing crowded conditions. The average daily census in the prenatal session at the time of this study was 80 (range 70-120) with 20 new patients.

Every new patient, after the initial medical evaluation, was instructed to proceed to the dental office. After a dental history and examination, she was advised of the findings and alternatives for therapy. The condition of teeth, gingiva, and other findings were charted. The hygiene and nutrition status were recorded. Nutrition and prophylaxis were emphasized during counselling. Patients were referred to the department of oral surgery when extractions were indicated.

Results

During the 20 month study period (October 1973 through May 1975), 2,200 women were examined. Initially, some were reluctant to par-

ticipate, but this feeling soon disappeared. Those examined included 1,831 black, 79 white, and 290 Hispanic women.

There were 135 women in the second month of pregnancy, 180 in the third month, 218 in the fourth month, 190 in the fifth month, 301 in the sixth month, 380 in the seventh month, 426 in the eighth month and 370 in the last month of pregnancy. Table 1 illustrates total findings. The number of filled teeth found were fewer than the number of carious teeth; treated teeth are not reported.

All stages of periodontal disease (gingivitis, periodontitis and periodontal abscesses) were encountered. Gingivitis is the inflammation of the gingiva (redness, swelling and bleeding). In acute gingivitis the gum will be bright red; ulceration and hemorrhage are common. The gums are usually painful. Chronic gingivitis is associated with an overgrowth of tissue. The gingival sulcus deepens because of the disease and a pocket is formed. This pocket facilitates abscess formation because of poor drainage. Improper hygienic measures compound the problem.

Table 1
Total Findings in 2,200 Women Examined

Missing Teeth	4895
Periodontal Disease	373
Carious Teeth*	5711
Extraction Indicated	(1032)

*Number of teeth, not number of caries.

In addition to the gingiva, periodontitis compromises the deeper tissues of the periodontium; besides pocket formation, there is bone destruction. This disease is considered a progression of a neglected gingivitis. Although the disease is originated by extrinsic irritational factors, it may

Table 2
Oral Findings According to Age

Age	Number of Patients	Periodontal Disease		Carious Teeth	
		Number	Percent	Number	Percent
12-16	332	99	30	225	68
17-20	858	797	93	677	79
21-25	495	460	93	405	82
26-30	241	216	90	195	81
31-46	274	246	90	224	82
Total	2200	1818	79	1726	78

Table 3
Recommendations

Age	Number of Patients	Prophylaxis		Extraction	
		Number	Percent	Number	Percent
12-16	332	120	36	63	19
17-20	858	352	41	403	47
21-25	495	248	50	257	52
26-30	241	166	69	186	77
31-46	274	140	51	99	36
Total	2200	1026	49	1008	46

be complicated by underlying diseases such as endocrine disturbances and nutritional deficiencies. Periodontal trauma is another etiological factor. Periodontal abscesses occur in cases of extreme deep pockets, especially of the intra-alveolar type.

Noncarious teeth were found in only 22% of the women studied (32% in the 12-16 years of age group; this decreased to 21% in the 17-20 years of age group).

Table 2 illustrates the pathology found according to age groups. The incidence of periodontal disease and carious teeth was found to increase with patient age. Indications for extractions and prophylaxis were higher in older women to a point, because the older patient was less likely to have teeth present (Table 3). Extractions were advised only when teeth were beyond repair, broken down, or retained, or in teeth with dead pulp. Oral hygiene condition in most patients was found to be poor.

Discussion

The oral status of the patients studied is bleak. It has been suggested that the endocrine changes related to pregnancy modify the already present etiological factors of periodontal disease; that incidence of gingivitis is high during pregnancy and it decreases following delivery.^{1,2} The findings of gingivitis and bacterial plaque are high. There is an increased tendency to bleeding; the gingiva is congested, edematous and hypertrophied. There is no evidence that pregnancy aggravates dental disease.^{3,4} Apparently, the general congestion of the pregnant state makes subclinical conditions obvious to the examining eye.

There has been little dental education in our classical prenatal services. This establishes another link in the vicious circle: what the mother ignores cannot be taught to her children and family. Physiological changes of the oral cavity

should be discussed with these women. At the same time, prophylaxis should be instructed.

These patients admitted to a lack of mouth hygiene, high ingestion of candy, pastries and sodas. In our experience, better rapport was established after closer communication. Knowledge of the importance of appropriate nutrition during pregnancy was minimal. They felt free to ask questions about the dental care of their families. Nutrition was reviewed.

As part of the educational program, the need to replace missing teeth was stressed. When missing teeth are not replaced, the remaining teeth will rotate, drift and aggravate the periodontal disease. Gingiva recession and malocclusion will become evident. All of these may also be accompanied by temporo-mandibular joint symptoms, such as pain, clicking and popping.

Another point given was a brief discussion about dental prophylaxis including the pathogenesis of plaque formation.

Oral and dental pathology discovered during pregnancy should be treated as in the nonpregnant state. If there is a need for radiological studies, a leaded apron should be employed. Extractions, fillings and bridges are not contraindicated. Local anesthesia is preferred.

Prophylaxes consist of the removal of plaque, removal of calculus and plaque control. Instruction included proper tooth brushing, flossing, and massaging of gums, none of which are contraindicated during pregnancy.

The volume of pathology found in this report strongly suggests the need for establishing similar services as part of the primary care. These findings are not at extreme variance with other studies reported.

This study also points to the important role obstetricians play in the diagnosis, prophylaxis, and educational aspects of diseases outside the female reproductive tract. The prenatal period may be also used for introduction of techniques

of community prophylaxis measures such as semi-annual use of stannous fluoride paste brushing.⁵

Conclusion

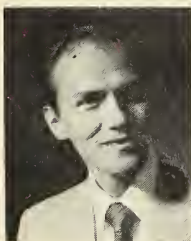
Oral cavity pathology is present in most of the women attending our prenatal services. The different types of oral pathology found are presented. The incidence is smaller in teenagers. Prophylaxis and educational efforts may improve the prognosis. The primary physician may play an important role in the diagnosis of this pathology by reminding patients to make routine visits to a dentist. ◀

References

1. Löe, H.: "Periodontal Changes in Pregnancy," *J. Periodontol.*, 26:209-217, 1975.
2. Cohen, D. W., Friedman, L., Shapiro, J., and Kyp, G. C.: "A Longitudinal Investigation of Periodontal Changes During Pregnancy," *J. Periodontol.*, 40:563-570, 1969.
3. James, J. D.: "Dental Caries in Pregnancy," *J. Amer. Dental. Assoc.*, 28:1857-1862, 1941.
4. Kullander, S. and Sonesson, B.: "Studies On Saliva In Menstruating, Pregnant and Post-menopausal Women," *Acta Endocr. (Kbl)*, 48:329-336, 1965.
5. Gish, C. W., Mercer, V. H., Stookey, G. K., and Dahl, L. O.: "Self-application Of Fluoride As A Community Preventive Measure: Rationale, Procedures And Three-year Results," *J. Amer. Dental. Assoc.*, 90:388-397, 1975.



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Case Report

Thoracic Outlet Syndrome Revisited

BY JOSEPH F. NORFRAY, M.D., Y. LERTSBURAPA, M.D.
AND H. M. HENRY, M.D./CHICAGO

A case of thoracic outlet syndrome illustrates the indications for arteriography. The rationale behind conservative versus surgical treatment is presented.

A 37-year-old janitor complained of increasing pain in the left arm and hand for 18 months. He could elicit the pain by turning the head towards the left, or sleeping with his left hand behind his head. On physical examination a bony prominence was palpated in the left supraclavicular fossa. Decreased sensation was present over the ulnar aspect of the left arm and hand. A bruit in the left supraclavicular fossa, and a drop in the blood pressure of the left upper extremity were identified during the provocative, painful maneuvers.

Radiographs of the cervical spine (Fig. 1), followed by left subclavian arteriograms in the position of rest (Fig. 2) and hyperabduction of the arm (Fig. 3) confirmed the clinical impression of thoracic outlet syndrome due to a cervical rib.



Figure 1
The cervical spine film shows an incomplete left cervical rib originating from C-7.

Because of the patient's severe symptoms, the cervical and first

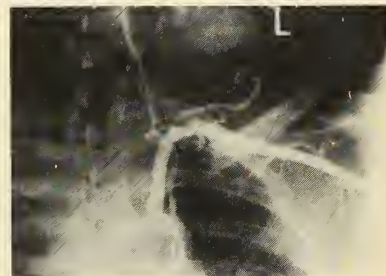


Figure 2
A left subclavian arteriogram is normal in the position of rest.

thoracic ribs were resected through an axillary approach. He has remained asymptomatic for 18 months following surgery.

Discussion

Rob and Standeven¹ coined the term "thoracic outlet compression syndrome," to include all the syndromes which stretch and compress the neurovascular bundle as it passes from the thorax into the arm. It is usually seen in young and middle aged adults, and occurs more frequently in women.^{2,3} Sag-

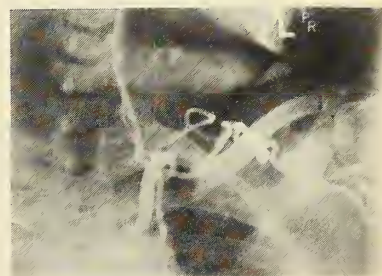


Figure 3
During hyperabduction of the left arm, there is complete occlusion of the subclavian artery with a large collateral vessel bypassing the obstruction.



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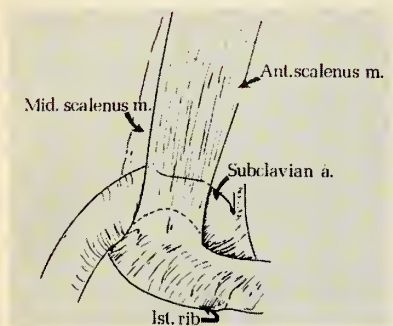


Figure 4
Neurovascular compression between the scalenus muscles.

ging of the shoulder girdle in middle age is a major etiological factor.

The anatomical sites of compression are: (a) the interval between the anterior scalenus and middle scalenus muscles (Fig. 4); a cervical rib further encroached upon this passage way (Fig. 5); (b) the interval between the first rib and clavicle (Fig. 6); and (c) the site where the neurovascular bundle passes beneath the insertion of the pectoralis minor muscle (Fig. 7). Compression at these sites is accentuated respectively by: (a) deep inspiration while the neck is fully extended—Adson maneuver; (b) bracing the shoulders downward and backward—military maneuver; (c) placing the hands on the back of the head—hyperabduction maneuver.

The symptoms are usually gradual in onset. In one series they were neurologic in 80%, vascular in 4%, and both neurologic and vascular in 16%.² The symptoms are elicited and aggravated by arm position.

Neurological symptoms are produced by compression of the brachial plexus—usually the contributions of the eight cervical and first thoracic nerve roots. Pain, numbness, tingling and other paresthesias are usually felt along the ulnar aspect of the arm and hand. Arterial symptoms consist of pallor, coolness of the hands or digits, claudication of forearm muscles, and unilateral Raynaud's phenomenon. Recent articles have stressed

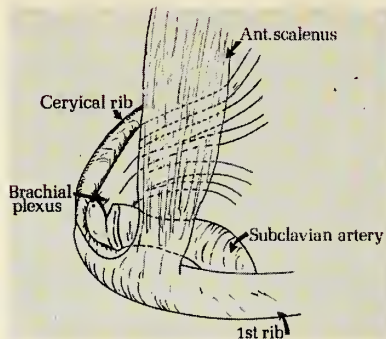


Figure 5
Neurovascular compression from both the scalenus muscles and the cervical rib.

that paresthesias are produced during distal embolization.^{1,4} Signs of vascular compression include a difference of blood pressure between the upper extremities of 10 mm Hg, a tender pulsatile mass in the supraclavicular fossa representing a subclavian artery aneurysm, a bruit in the supraclavicular fossa, and finger ulcerations of gangrene.

Arteriography is indicated when signs or symptoms of vascular impairment are present to rule out aneurysm, thrombus or embolus.⁴ The differential diagnosis of diseases causing vascular symptoms include: atherosclerosis, thromboangiitis obliterans, Takayasu's syndrome, fibromuscular dysplasia, and Raynaud's phenomenon.

Treatment is determined by the neurological or vascular presentation. Neurological symptoms may be treated with conservative management—strengthening the muscles to correct sagging of the shoulder girdle, and avoiding the positions which elicit symptoms.^{3,5} If the symptoms are severe and fail to be relieved by conservative means, excellent results are obtained by resection of the first rib, and if present, the cervical rib. The axillary and posterior surgical approaches are the methods of choice.^{3,5} When the arteriogram shows aneurysm, thrombus or embolus, treatment becomes a surgical emergency because of the possibility of amputation.⁴ The arterio-

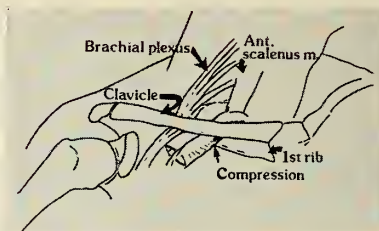


Figure 6
Neurovascular compression between the first rib and clavicle.

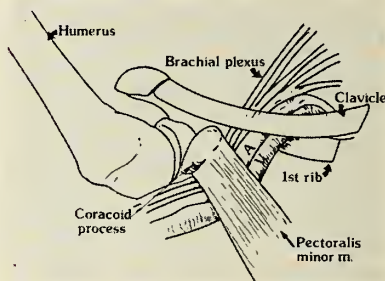


Figure 7
Neurovascular compression at the pectoralis minor muscle.

gram will determine the necessity of resection of the aneurysm or thrombectomy. The surgical approach to a subclavian aneurysm is through a supraclavicular incision with or without resection of the clavicle.^{3,4} The first rib and cervical rib should be excised during the same procedures through a separate axillary approach.³ ◀

References

1. Rob, C. G., Standeven, A.: "Arterial Occlusion Complicating Thoracic Outlet Compression Syndrome," *Br. Med. J.*, 2:709-712, 1958.
2. Kremer, R. M., Ahlquist, R. E.: "Thoracic Outlet Compression Syndrome," *Am. J. Surg.*, 130:612-616, 1975.
3. Rutherford, R. B.: *VASCULAR SURGERY*, Philadelphia, W. B. Saunders, 1977, pp 605-621.
4. Judy, K. L., Heymann, R. L.: "Vascular Complications of Thoracic Outlet Syndrome," *Am. J. Surg.*, 123:521-531, 1972.
5. Fairbairn, J. F., II, Juergens, J. L., Spittell, J. A., Jr.: *PERIPHERAL VASCULAR DISEASES*, Philadelphia, W. B. Saunders, 1972, pp. 459-475.

Recent Mortality Decline In Illinois

BY TSUKASA NAMEKATA, PH.D., EILEEN O'FARRELL, M.P.H., AND
BERTRAM W. CARNOW, M.D./CHICAGO

Although mortality statistics represent only one aspect of health status in our society, reducing numbers of deaths has been one of the most important goals of public health practice. High death rates mean large numbers of premature deaths which can be decreased by advances in medical treatment, social and economic improvements or changes in health habits and the environment. Mortality analysis may be a useful index to evaluate and develop priorities for disease prevention programs based on which disease entities provoke high-incidence mortality.

The Nation's Health¹ reported an accelerated downward trend in death rates in the United States in the 1970's. Declines were observed for most major causes, especially for heart and cerebrovascular diseases. Cancer deaths, however, showed a gradual increasing trend which has persisted for the past decade.

Also, recent mortality declines were reported

in Chicago. An article appearing in a local newspaper exaggerated the significance of this drop in mortality when it stated, "Chicago's death rate is going down again this year as Chicagoans continue to enjoy longer and healthier lives."² It is not always appropriate to relate a decrease in death rates directly to longer and healthier lives. For example, it is likely that a population with a sharp increase in numbers of young people or one which has had a decrease in older age group population size will experience a decrease in the death rate, as fewer people die at young ages than at old ages.

The purpose of this paper is to examine the recent mortality trend in Illinois by eliminating the effect of age factors in the population. In order to observe the mortality trend in Illinois, we used annual vital statistics reports published by the Illinois Department of Public Health.³ Age-adjusted death rates based on the 1970 population of Illinois were computed to eliminate variations in the age composition of the population as an influencing factor on mortality rates. A computation method to standardize death rates can be seen from demography textbooks.^{4,5}

Figure 1 shows crude death rates and age-adjusted death rates from all causes for Illinois, Chicago and downstate residents from 1967 to 1975. Some differences exist between crude death rates and age-adjusted death rates of the three groups. For comparison purposes, it is more appropriate to use age-adjusted death rates than crude death rates, since an age-adjusted death rate summarizes a set of age-specific death rates independent of the population age composition. Therefore, only age-adjusted death rates will be cited hereafter unless otherwise specified.

Age-adjusted death rates in Illinois have been decreasing since 1968. The difference in the rates between 1967 and 1975 was one death per 1,000 residents. In other words, 13,000 lives were saved in 1975 compared with expected deaths in 1967, when we used the 1970 standard population of

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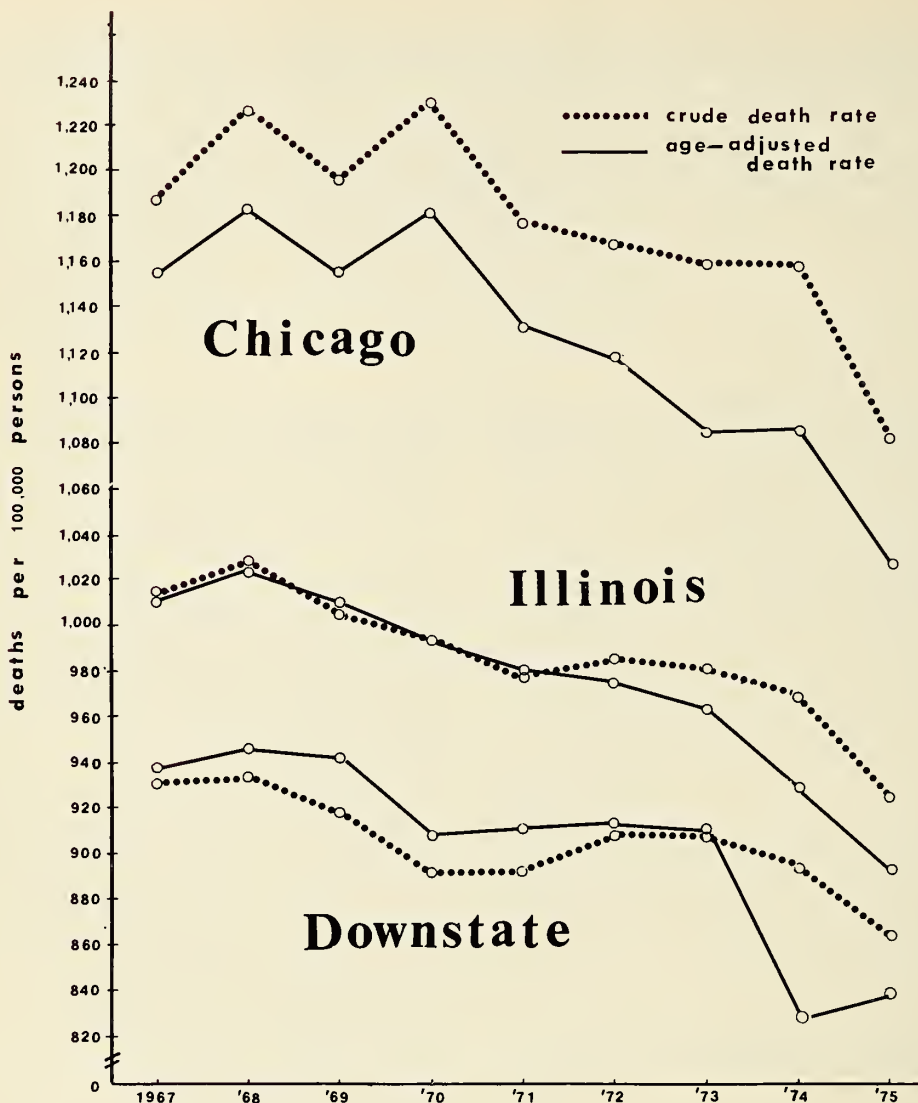


Figure 1
Crude death rates and age-adjusted death rates in Illinois, Chicago and downstate from 1967 to 1975.

Illinois.

If we divided all Illinois residents between those of Chicago and downstate, some differences appear. Death rates for Chicago have been consistently declining since 1970, whereas death rates for downstate decreased in 1970 and again in 1974-75 with no change observed between 1970 and 1973.

In order to assign mortality declines to some type of illness, we computed age-adjusted death

rates of five major causes which accounted for 75% to 80% of all deaths. As shown in Figure 2, the greatest mortality decline in total deaths was that related to heart disease. Decreasing patterns in death rates of heart disease are almost identical to those in age-adjusted death rates for total deaths in Illinois, Chicago and downstate (Figure 1). Also, less declining trends were observed in cerebrovascular disease, accidents, pneumonia and influenza. Death rates for malignant neo-

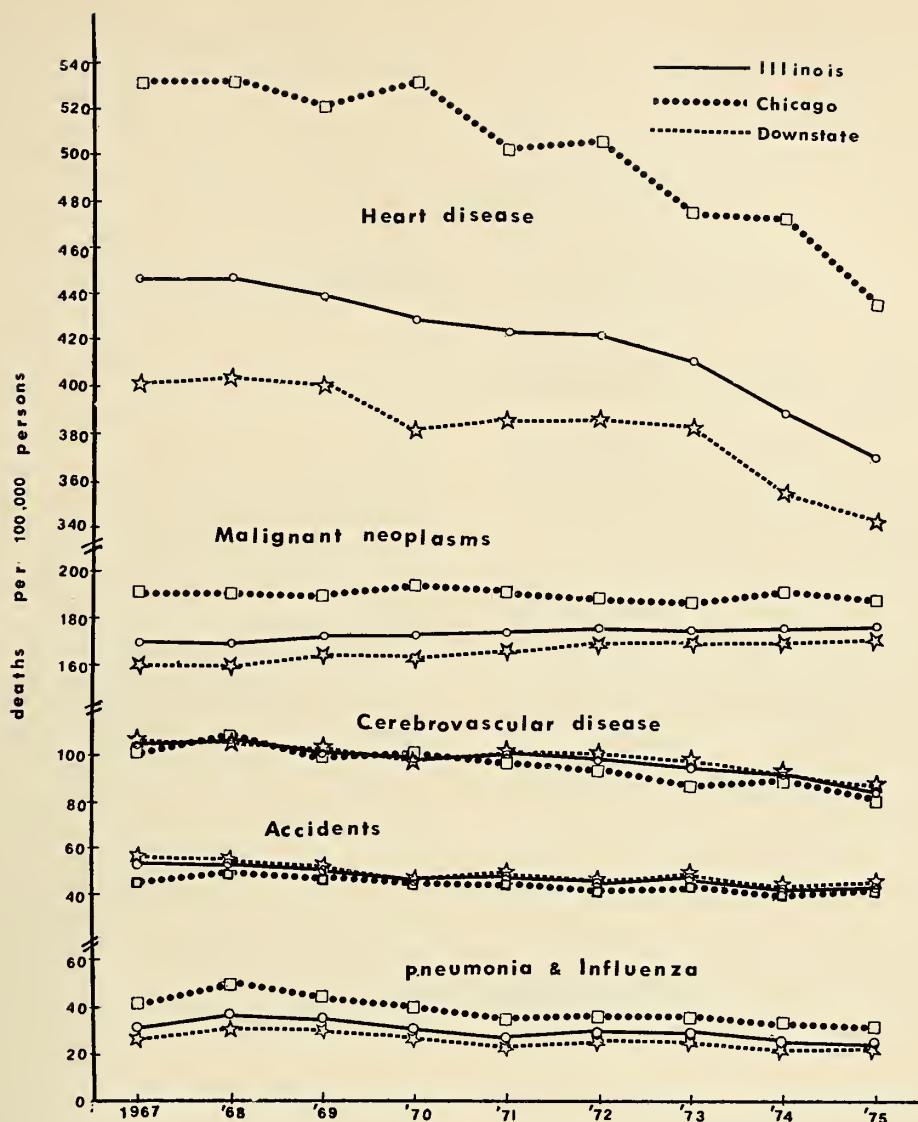


Figure 2
Age-adjusted death rates by five major causes in Illinois, Chicago and downstate from 1967 to 1975.

Table 1
Changes in Age-adjusted Death Rates for Major Leading causes from 1967 to 1975 (deaths per 100,000 population)

Causes	Illinois	Chicago	Downstate
All Causes	-118.5	-127.6	-99.3
Hearth Disease	- 74.8	- 93.5	-58.8
Malignant neoplasms	+ 7.3	- 0.9	+12.8
Cardiovascular disease	- 19.7	- 20.5	-19.4
Accidents	- 9.1	- 2.6	-12.2
Pneumonia & Influenza	- 5.9	- 10.1	- 2.9

Note: Age-adjusted death rate computations were based on the 1970 population of Illinois.

plasms increased in Illinois and downstate but were unchanged in Chicago. Table 1 indicates differences in age-adjusted death rates for these major leading causes between 1967 and 1975. Death rates from all causes decreased to 118.5 per 100,000 persons in Illinois, 127.6 in Chicago, and 99.3 downstate. The death rate for persons in Chicago in 1975 was in fact 12.6% less than in 1967. This great decline represents a decrease in deaths from all five major leading causes.

Overall, mortality rates are shown to have declined in Illinois when age is adjusted. Particularly, the decreasing death rate for heart disease is quite impressive. In spite of this drop, however, the death rate for heart disease in Illinois, 409.3 deaths per 100,000 population, was the fifth highest among the 51 states in 1974.⁶ When compared to 349.2 deaths per 100,000 population in the United States, the death rate for heart disease in Illinois would appear considerably high.

Heart disease prevention and early treatment remains a priority. The fact that cancer is the only major cause which has not declined is also

of concern. Since 85-90% of all cancers are environmentally related, they can be reduced or eliminated by more closely examining our habits, diets, community environment, pollution and the presence of carcinogenesis in the workplace. It would appear that this group of diseases, in addition to those of the heart, also require continued major preventive consideration.

In summary, proper consideration of mortality statistics and trends can serve as a useful tool in developing priorities in health intervention. ◀

References

1. "Mortality Decline Increasing," *The Nation's Health*, May, 1977.
2. "Chicagoans Live Longer and We Enjoy It More," *The Chicago Tribune*, Dec. 12, 1976.
3. "Vital Statistics Illinois 1967-75," Illinois Department of Public Health, Springfield, Illinois.
4. Matras, Judah: *POPULATIONS AND SOCIETIES*, Prentice-Hall, Inc., 1973.
5. Barclay, George W.: *TECHNIQUES OF POPULATION ANALYSIS*, John Wiley & Sons, Inc., 1958.
6. *STATISTICAL ABSTRACT OF THE UNITED STATES: 1976*, The U.S. Government Printing Office, 1977, p. 66.

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Guest Editorial

Medicine And The Law An Historical Perspective

The following is the text of a talk given before the ISMS Student Business Session on April 1, 1978, as part of a symposium on "Law, Litigation and Medicine."

BY STEPHEN R. ELL/FOREST PARK

The current interest in medico-legal issues arises from the litigiousness of our society, rather than from interest intrinsic to the subject. Without any great change in the statutes, a situation has arisen in which physicians live in fear of patients' legal recourses. The law has changed little, but the needs served by the law have. Law is one of the tools by which societies reform their components. I would like briefly to sketch some of the roots from which the legal apparatus regulating medicine arose. At the same time, I will attempt to suggest how the historical development of society's expectations of medicine has contributed to the present situation. In doing so, I will concentrate on four major changes in medicine's position in society.

The first might be termed the change from the concept that "the gentleman makes medicine" to the idea that "medicine makes the gentleman." In the Roman law, medicine was an occupation of the free man, one of the liberal arts. The physician was not entitled to a fee for his services. He might accept an *honorarium*, just as a clergyman today might for performing a marriage ceremony, or a scholar would for giving a guest lecture. The payment of an *honorarium*, however, depended upon the means and goodwill of the patient. Medicine was an occupation whose reward was its exercise rather than the remuneration it provided.

Upholding Christ as the ideal physician, the men of the Middle Ages emphasized goodness and virtue as the physician's hallmarks. St. Benedict made the care of the sick one of the duties of the monk. It was a rare saint who did not cure illnesses. The result of this religious imagery was an emphasis on the physician's personal qualities over his skills. Medicine became a means by which the man of good intent might acquire virtue.

Popular conceptions of the ideal physician have changed little from the imagery of classical and medieval times. Rarely is a physician admired for his technical competence. Patients admire their physicians because they are unconcerned with money, because they are compassionate, or because they work long hours. In many ways, the public expects a physician to practice as if he lived in the days of Hadrian.

As medicine has become more a technical skill and less a gentleman's pastime, conflict has arisen with the older concepts. We might recall that a man like Thomas Jefferson counted among his many abilities those of a surgeon. As a symbol of what was to come, we might consider the image of Pasteur testing his rabies vaccine in the hope of saving the life of a single child. Pasteur's compassion, his unworldliness and his willingness to take a grave risk represent the highest personal qualities. Pasteur, however, was not a physician and was opposed by many who were.

In our own day, the classical ideals have been overturned. Many physicians come to the U.S. from elsewhere for what are often perceived as economic reasons. Medicine arouses not only

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xenophobia but the suspicion of greed. Where gentlemen used to make medicine, medicine now has the power to make someone a gentleman, at least in economic terms.

Governmental Influences

The second major development to be considered is the entry of the state into medical care. A significant part of this movement came during the Renaissance. We have noted that much of medieval medicine centered on the virtue of the practitioner. In such cities as Venice nearly all hospitals before 1400 were founded by individuals or families as pious philanthropies. In the fifteenth and especially the sixteenth century, the state took over this initiative, not only founding hospitals, but isolating the sick and imposing quarantines. Renaissance thinkers, who revived the *res publica* and hailed its capabilities, set the stage for the state to acquire the virtue which had once been attributed to individuals. St. Louis of France who cured the King's Evil with his touch gave way to the anonymous public health officers of the Venetian state who first took steps to control epidemic disease. At its first entry into medicine, the state enjoyed a real success. What medicine could not yet cure, the state could prevent.

Birth of Pathology

The end of the eighteenth century saw the next crucial development, that which Michel Foucault has called "the birth of the clinic." The medicine of symptoms gave way to one based on pathological anatomy. Disease ceased to be a catalog of symptoms with vague, philosophical causes. The lesions underlying illness came to the fore, as did the possibility of effective and rational treatment. This rationality shifted the statutes regulating medicine away from the preservation of proprieties to the maintenance of professional standards. The Visigothic law of the sixth century concerned itself with such issues as whose presence and permission were required for a physician to examine a female patient. Recognition of the pathological basis of disease, in my opinion, effectively permitted the law to treat the substance of medical practice rather than its etiquette.

We tend to forget how little medicine had been able to do. Physicians have always treated all diseases. The treatments, however, did not always work. One Renaissance image of the physician describes a pompous chap with a flask of

urine in one hand and a sack of coins in the other. The academic physician was a somewhat comic figure, a sort of absent-minded professor with sinister overtones. The historian J. R. Hale described the Renaissance physician as a "man who charged heavily for failing to do his duty," words which could apply until very recently.

Our own century has seen a vast change in the efficacy of medical treatment. There is no need to belabor the decline of epidemic diseases or the precipitous fall in childhood mortality. It was said of Charlemagne that he engendered such strong children that only a handful of them died. Many of our own grandmothers lost children; not so our wives. The death of a child is now an unfamiliar and unjust event. Modern medicine is potent, but expectations of it are greater still. It is an historical commonplace that revolutions occur after conditions have begun to improve. Improvement suggests possibilities which cannot be realized, and frustration follows.

Medicine has changed from a means to private virtue or a purely academic discipline to a profession with an immense impact on the individual and his society. The intellectual baggage medicine carries, however, is that of other ages. The popular image of the physician is a mix of classical and medieval elements. Most previous advances in health came from the state rather than from physicians. Many of the philosophical and ethical foundations of medicine are as old or older than Hippocrates. The combination of a technically revolutionary discipline in an obsolete moral framework is one destined to provoke immense mistrust.

Medicine stands like Janus, looking forward and back. The law is a tool by which society can make medicine more consonant with its needs. It is less the law which we need comprehend than the pressures which cause it to modify medicine. That medicine will change drastically seems inevitable, though the direction is unclear. Rather than fight a rearguard action, defending lifeless privilege, physicians might well attempt to provide medicine with a new philosophical foundation, one more harmonious with its social setting. At such a moment of change, there is every misgiving, every fear. I would recall to you another face of change, however, one captured by Apollinaire:

*Et la nuit de septembre s'achevait lentement
Les feux rouges des ponts s'éteignaient dans
la Seine
Les étoiles mourraient le jour naissait à peine*

In Good Hands

Robert King Stone, M.D., Physician to Abraham Lincoln

J. K. CRELLIN, Ph.D., L.R.C.P., M.R.C.S./North Carolina

Quality of medical care is notoriously difficult to assess at any time. It is especially difficult for 19th century America, not only because the historical record is sparse, but also because of the wide spectrum of practitioners. These included irregular (e.g., botanic practitioners and homeopaths) as well as poorly educated, regular practitioners. Amid the confusing array, the public image of orthodox medicine was often low.¹ In consequence there is a tendency to forget that many practitioners were highly regarded by patients and colleagues. Certainly those associated with Abraham Lincoln had, or were to develop, first-class reputations.² Although the reasons for each reputation were varied and need further study, the good quality care they provided was probably a common feature. This article endeavors to make some general assessment, largely through his case books, of the quality of care provided Lincoln by Robert King Stone (1822-1872), the Washington family physician during his presidency.

Even a cursory glance at the neatly written case books covering the years (with small gaps) 1863-1869 is a reminder of Stone's considerable reputation among his contemporaries and his particularly good education.³ He had a Princeton College B.A. (1842), a University of Pennsylvania M.D. (1845) and had undertaken a period of study (with special emphasis on eye diseases) in Europe. On returning to America, Stone established a practice in Washington and also be-

came conspicuous in the National Medical College. Among the appointments he held there were professorships of anatomy and of ophthalmic and aural surgery. From around 1860, following a disabling carriage accident, Stone concentrated on private practice.

It is not clear how he came to be chosen as Lincoln's family physician, particularly as political views may have placed him at a disadvantage. One well-wisher specifically warned Lincoln not to consider Stone (as well as several other physicians) saying that they were democrats (the most "bitter kind of opponents of the Republicans") and should not be employed.⁴ The well-wisher, it should perhaps be added, had unhappy experiences in Washington. He had lived there until 1855 with "much sickness, and the loss of five children out of ten despite the efforts of the best physicians."

Unhappily nothing seems to have been recorded of the relationship between Stone and the Lincoln family, although there were many problems that must have concerned him. For instance, the death of son Willie Lincoln in 1861, Lincoln's possible mild case of smallpox at the time of his Gettysburg address (he thought he gave the disease to Willie Johnson, a negro servant from Springfield, who died) and Lincoln's many symptoms during the war. Stone certainly felt free to use "Executive Mansion" notepaper to draft a letter to Lincoln in 1863, asking for Lincoln's aid in controlling "pestilential odors, which invade our city with great regularity, at the most dangerous hours of midnight . . . when the body being in repose, is less able to resist the noxious influence." Stone said that the cause was the open fire cremation of army animals. He added that "modern science has devised no better plan for getting rid of the pestilential effects of animal decomposition, on a large scale—than this—a trench deeply dug in the soil; so that, some feet of earth, may

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solidly cover the matter to be *consumed*. Two adjuncts need only to be added, charcoal powdered—or the less expensive Quicklime.”⁵

Careful Record Keeping

The letter suggests that Stone kept abreast of developments in medicine and related fields, something which is also reflected in his careful case books. Each patient was entered in the order seen (except for most home visits). After the name and date, a diagnosis is noted, followed by pertinent data about the history and symptoms, and a full record of therapy. Stone specialized in eye problems (23 of his first 100 new patients in 1863), but his practice also included almost every conceivable medical problem. For example, colds and sore throats, influenza, venereal disease, hepatic obstruction, atonic dyspepsia, and “excessive uric acid and lithiasis,” are noted.

Straight forward problems were generally written up in perfunctory style. In more complex cases, details were often given in full. Occasionally they were written in French, as when Stone gave a lengthy account of a patient with post-abortion problems. On another occasion (5 June 1868) he wrote in English about a thirteen year old Paul Roux (son of a French chef) who had:

fixed pain, R side of Abdom, (to R & outward of umbilicus), walks bent *over*, since Sunday *very tender*, on pressure with finger tips—easier on pressure with open palm if steady.—Tongue dirty—Pain shoot to *root of penis*—Urination is scanty & painful, burns him at *orifice* . . . Bowels are confined—tho’ he had *slight action* from Ayers Pills—It is a *muscular* rheumatism of the abdoml muscles of the R side—with some lithiasis.

Stone’s therapy in this case involved the immediate administration of Seidlitz powders and the application over the pain of hot packs (to be changed when they cooled) of flannel bags filled with salt. Also to be taken (three hourly) was Milburn’s Vichy Water containing powdered gum acacia and sweet spirit of nitre. The patient improved rapidly.

Many of the case histories were accompanied by excellent thumb-nail sketches to depict, for example, eye lesions or the size and position of enlarged neck glands. Stone’s notes suggest that his physical examinations, when necessary, were thorough and systematic. He often used relatively new equipment such as the auriscope and ophthalmoscope, which, if only because of technical

lighting problems, were not easy to use at the time. Stone’s histories also, on occasions, mentioned negative findings, something then only becoming a feature of case history reporting, and which reflected the growing sophistication of the physical examination and of differential diagnosis. On 2 April 1868, Stone wrote of a “tall, finely formed & robust [female with an] *abdominal wall very firm & resistant*—requiring much pressure to find the swelling complained of—No aneurismal thrill whatever.”

How many questions Stone asked of his patients is not clear, though at the time questioning had become a key feature of history taking, rather than relying merely on a patient’s story. In the case of a fifteen year old youth suffering from epilepsy, seen on 10 March 1863, he unsuccessfully tried to establish whether the youth masturbated (believed by many to be a cause of epilepsy). He could only write “suspect it.”

Stone’s case notes, taken in their entirety, reflect the work of a conscientious physician. Equally, his prescribing suggests that he had a great concern with the general needs of his patients. His therapeutic regimens were elaborate, and whatever the problem he seemed to prescribe a “bottle” of medicine, frequently a tonic such as syrup of hypophosphates (one of Stone’s favorite remedies which he often combined with iron). He had standard (though sometimes modified to suit individual idiosyncrasies) regimens for many problems. The basis of his gonorrhea treatment was three internal medicines: balsam of copaiba drops, compound tincture of gentian and a “diluent” medicine. Additionally, a lotion containing lead, zinc and opium was applied to the genitalia. By and large Stone’s therapy is easily rationalized within the context of his time. Undoubtedly, too, he kept himself up-to-date as demonstrated by his use of such relatively new drugs as bromides.

Unfortunately, none of Stone’s private thoughts about his patients appear in the notes, unlike those of his physician son, Thomas Ritchie Stone. An example from the latter’s case histories is as follows.⁶

Thanks from ignorant people is at best a surprise but when they begin to put on airs I can’t and won’t stand it. They not being satisfied have notified them I will not be in the case any longer. (17 March 1890)

Thomas’ advice at times was probably blunt.

About one patient he wrote:

Feeling O.K. ordered her to keep up the Fellow's [syrup] and to leave *all Patent Medicines alone*. Plenty of beef-steak and good food & to go outdoors & get fresh air. (16 January 1890)

Kind Personality

Even if the same outspokenness does not appear in the father's notes, father and son undoubtedly shared a keen sense of humanity and much common sense. Nothing has been found to undermine the following comment about Lincoln's physician from an eulogy published in 1873: "his genial intercourse with his patients was characterized by kindness and liberality, especially towards the suffering poor."⁷ There is little doubt that Lincoln, and many other prominent Washington citizens, chose a physician, who, within the context of this time, was first-class. Highly regarded by patients and colleagues, he is also an excellent reminder that at a difficult time for orthodox medicine in America, many American physicians upheld the flag of excellence. Their quality of practice was comparable to the best of European practitioners. ◀

Acknowledgement

I am grateful to Dr. Emmet F. Pearson for helpful comments.

References

1. The public image did not remain static through the century. Nevertheless, it is the more critical comments that are generally recorded and remembered. Cf., for example, Rothstein, W. G., *AMERICAN PHYSICIANS IN THE NINETEENTH CENTURY*, Baltimore and London, 1972, especially pp. 125-128.
2. For a still useful general account of physicians associated with Lincoln see Shutes, M. H., *LINCOLN AND HIS DOCTORS*, New York, 1933. See also Pearson, E. F., "Abraham Lincoln-Health, Habits and Doctors," *Ill. Med. J.*, 1975, 147, 143-147.
3. For a short biography, see Kelly, H. A., and Burroughs, W. L., *AMERICAN MEDICAL BIOGRAPHIES*, Baltimore, 1920, p. 1111. The case books are in the Trent Collection, Duke University Medical Center Library.
4. Letter, dated 28 November 1860, from John Wilson. Reproduced in Mearns, D., C., *THE LINCOLN PAPERS*, Garden City, 1948, Vol. 1, pp. 318-319.
5. Letter in Trent Collection, Duke University Medical Center Library.
6. Case Book in Trent Collection, Duke University Medical Center Library.
7. *TRANS. AM. MED. ASSN.*, 1873, 24, 339.

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Access For The Handicapped

The federal government has announced that a series of seminars is scheduled for physicians and health workers to discuss avenues to comply with the regulations described below. The seminars will cover cost-effective strategies, implementation of compliance regulations and administrative problems. The Chicago seminars are scheduled for April 30-May 1 and June 11-12. Further information may be obtained by writing the National Institute for Advanced Studies, 2021 K St. NW, Washington, D.C., 20006; (202) 857-1900.

The Department of Health, Education and Welfare has issued much disputed regulations regarding the rights of physically or mentally disabled persons to services and jobs wherever HEW federal funds, services, or property are involved. These regulations implement Section 504 of the Rehabilitation Act of 1973 and will be subject to considerable interpretation in the coming months. They define and forbid acts of discrimination against "qualified" handicapped individuals in employment, as well as in the *operation of programs and services*. Providers of services must ensure that their programs are operated in facilities that are readily accessible to handicapped individuals, that all new facilities constructed be accessible to handicapped individuals, and that the programs operated in such facilities are operated in a nondiscriminatory manner.

As it stands now, the Bureau of Health Care Financing has determined "federal funding" includes those services which are provided by a physician involving Medicaid or Medicare reimbursement. However, a court case is pending which may limit the regulation's applicability to services provided for under Medicaid. If you are a private physician serving patients who are beneficiaries of either service, you must:

- Have an office physically accessible to handicapped patients, or
- Treat handicapped patients in a hospital or at home, or if this is not possible, and you have fewer than 15 employees,
- Refer them to another physician whose office is accessible, after consulting with the handicapped persons.

According to HEW, administrators of a health care or social service facility (such as clinic managers) are required under Section 504 regulation to:

- Evaluate the quality and availability of services to handicapped persons and begin to correct inequitable policies or practices.
- Make the evaluation with the assistance and expertise of disabled persons.

Physicians' offices and clinics are *not* required to provide ramps, elevators and other devices to remove physical barriers in *every* part of a single building or in every building, according to the regulation. However, they are required to:

- Make every program or service, *viewed as a whole*, accessible to handicapped persons—be they mobility impaired, blind, deaf, afflicted with alcoholism or drugs, etc.
- Make structural changes where needed in existing buildings to provide access to services or programs or provide such alternatives as home visits or relocation of programs to accessible sites.



Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 26, 1978

Case Report

Blunt Trauma of the Heart and Great Vessels

Dr. Lawrence Michaelis: Today we are concerned with blunt trauma to the heart and great vessels, and will include the presentation of several patients to illustrate types of injury commonly encountered. The first is a man 40 years old. He was involved in an automobile accident in December, requiring hospitalization for some left side rib fractures. About the fifth hospital day, an electrocardiogram demonstrated that this healthy young man had a rather massive myocardial infarction involving the anterior portion of the left ventricle, part of the lateral wall of the left ventricle, and the anterior portion of the right ventricle. It probably also included the interventricular septum. He recovered, but during several ensuing months, he gradually deteriorated. His problems were dyspnea, shortness of breath, and unexplained cyanosis. His PO_2 was 39 on 100% oxygen and room air. He had recurrent bloody

pleural effusions on the left side that were tapped repeatedly. Finally, he had a right heart catheterization and was referred to the Northwestern Memorial Hospital. When admitted, his chest X-ray showed massive biventricular hypertrophy. Physical examination revealed distended neck veins, a pulsatile liver and a systolic ejection murmur that could be heard along the right sternal border, which are signs of tricuspid regurgitation. Although the patient did not have a history of heart disease, he was intensely cyanotic.

The differential diagnosis included traumatic pulmonary A-V fistula, although a murmur over the lung fields was absent and he did not have classic radiographic findings of an A-V fistula. Pulmonary angiography was performed and was normal. The possibility of multiple pulmonary emboli was considered, but once again the pulmonary angiogram was normal, so that repeated

small pulmonary emboli were not responsible for his profound hypoxia.

The next study was a contrast aortogram with right sided heart injection. The right ventricle and artery were outlined. He was found to have a right to left shunt at the atrial level. He had a huge right atrium and a huge right ventricle with tricuspid regurgitation. Our diagnosis was cyanosis due to poor contractility of the right ventricle with tricuspid regurgitation, and right to left shunting through a patent foramen ovale.

Our chief preoperative concern was whether the tricuspid regurgitation represented severe right heart failure. At operation, he had dense, bloody, pericardial adhesions, but vigorous contraction of the right ventricle. The patient was placed on the cardiopulmonary bypass, and we encircled the aorta with a tape. We measured his cardiac output with an electromagnetic flow probe around the ascending aorta. The major pathologic finding involved the anterior leaflet of the tricuspid valve. The papillary muscle of that anterior leaflet had been avulsed, causing this leaflet, the largest of the three tricuspid leaflets, to become incompetent. Ruptured cords of the tricuspid valve are usually well tolerated, but when an entire papillary muscle is ruptured, tricuspid regurgitation is usually quite severe.

We excised the leaflet of the tricuspid valve in order to replace it with an artificial valve. When replacing the tricuspid valve, one must be very careful not to excise too much of the leaflet itself, because in this area one is close to the heart's conduction system. To prevent heart block, the sutures are placed with the heart beating and the coronary arteries perfused. Because it is the right side of the heart, there is no danger of getting any air into the heart and the other leaflets of the valve were perfectly normal.

A sizer is used to select the appropriate size of prosthetic valve. For replacement of the tricuspid valve in this patient, we selected a porcine xenograph—the aortic valve of a pig that is stabilized with glutaraldehyde; the foreign protein is thereby completely denatured.

History

We are now in our eighth year of experience with this valve. The first one was inserted in 1970 and to date the record is very good. This artificial heart valve does not require anticoagulation, which is especially helpful in the tricuspid valve because of the low velocity flow on the right side of the heart. The older, rigid heart prosthetic valves were especially susceptible to thrombus for-

mation and multiple pulmonary emboli. The atriotomy is closed and air is evacuated from the right side of the heart. The patient was weaned from cardiopulmonary bypass without difficulty. His PO_2 on 50% oxygen was 175 when the heart/lung bypass was discontinued. He had an uneventful postoperative course. To be sure that we weren't in any danger from low cardiac output following tricuspid replacement, we measured aortic blood flow with the electromagnetic flowmeter after bypass and saw that it was exactly identical to that recorded prior to cardiopulmonary bypass.

The patient's heart size was reduced dramatically following this procedure and he was no longer cyanotic. A pacemaker is inserted prophylactically in all patients who have a tricuspid valve replacement.

The common denominator in most people with blunt chest trauma is the steering wheel. Although many other organs may be affected, the steering wheel and the sternum have a propensity to meet each other with rapid deceleration. Although the heart is protected by the sternum and the ribs, it really hangs by the great vessels in the chest wall. The heart can be injured when sudden deceleration causes a collision with the chest wall. It can be injured by compression between the steering wheel and the vertebral column. Valvular tears, subendocardial hemorrhages and rupture are also attributed to sudden increases in intrathoracic pressures and to intravascular hydrostatic pressure, due to rapid compression of the abdomen and sometimes the lower extremities. These forces sometimes fill the heart quickly to bursting pressures. Also, fragments of the bony chest wall may penetrate the heart and great vessels.

Warning Signs

Following chest trauma, we must look for clues to injury of heart and great vessels. A bruise on the sternum suggests a fractured sternum. Anyone with a fractured sternum should be admitted to the hospital for investigation of possible underlying injury to the heart. These patients should have serial electrocardiograms for reasons we shall discuss later. Cyanosis of the upper half of the body suggests the possibility of injury to the heart and great vessels. Atrial or ventricular arrhythmia in someone without previous rhythm disturbance is compatible with cardiac hemorrhage. Although an electrocardiogram may appear normal, premature ventricular contractions or aberrant atrial contractions in a normal healthy young person may indicate injury to the heart muscle.

The treatment of common myocardial contusion, a bruise of the myocardium which may or may not cause hemopericardium, is generally supportive. Surgery is seldom indicated. The therapeutic measures are those which are appropriate for myocardial infarction, cardiogenic drugs, treatment of rhythm disturbances, plus a Swan Ganz catheter. Occasionally, an intraaortic balloon must be inserted in these patients. Hemopericardium may occur and injuries at all layers of the myocardium may result from blunt trauma. Other injuries that can occur include atrial rupture, complete rupture of the right ventricle (these patients seldom arrive alive at the hospital) and rupture of the interventricular septum.

Pericardial Tamponade: Management

The following discussion concerns the management of pericardial tamponade from hemopericardium. It is my opinion that every physician should know the emergency treatment of pericardial tamponade. A large number of people die because someone is afraid to stick a needle into the pericardial sac. The signs and symptoms are usually pathognomonic and are fairly consistent. The patient may or may not be in shock. The blood pressure may be normal. However, the neck veins are almost always distended, unless the patient has lost a significant amount of blood from other injuries. Heart sounds are usually distant. The paradoxical pulse is very seldom seen in the acute situation. A significant tamponade can exist with a fairly normal blood pressure because of the compensatory mechanisms. One factor is peripheral vasoconstriction, which increases the blood pressure. Another is tachycardia. Profound tachycardia increases cardiac output with the smaller stroke volume. The venous pressure rises and venous return increases. Thus, the pressures tend to equalize inside and outside the cardiac chambers. However, as venous pressure rises, arterial pressure doesn't change until one reaches a point where cardiac output falls precipitously. The patient who has a pericardial tamponade with a normal blood pressure, but who has air hunger and distended neck veins, is in grave danger. One certainly can have a rather significant amount of tamponade and demise may be imminent as soon as the venous pressure rises enough.

Tamponade can be completely contained in the pericardium. In small wounds, pressure may equalize and the bleeding cease. Sometimes the pericardium may be torn, and the bleeding will continue into the left chest or even into the peritoneal cavity.

The treatment of suspected pericardial tamponade or hemopericardium is pericardiocentesis. Most cardiac surgeons prefer the subxiphoid approach; a 17 gauge needle is inserted under the xiphoid about the level of the seventh rib and is directed posterior toward the left shoulder. Some people recommend attaching an electrocardiogram and looking for an "injury pattern." Generally speaking, that is not necessary. Most of the time you will know if you are in the pericardial sac or not, because the patient will improve from the aspiration of as little as 20-30 ml. of blood. Often, pericardial blood is not clotted, because of the fibrinolysins that are present in the pericardial sac. However, if bleeding has been brisk, the pericardial blood may clot. When pericardial tamponade is suspected, the first procedure is immediate pericardiocentesis. This is often a life saving measure.

A patient who has significant intrapericardial bleeding must be taken to the operating room on an emergency basis. Pericardial aspiration should be performed before the patient is moved, and a catheter may be threaded into the pericardium. If the patient is really in extremis, you can open the pericardium with local anesthesia or no anesthesia at all, in the subxiphoid region, and insert a finger or an intercostal catheter into the pericardial space to evacuate the blood while the patient is being transferred to the operating room. Numerous incisions have been advocated. Some prefer a left thoracotomy, others use a median sternotomy. The basic principle is that when pericardium is opened be prepared for the onslaught of a great deal of bleeding and be prepared to control the bleeding promptly. I might add that probably the greatest hazard to a patient with a significant pericardial effusion or hemorrhage is the induction of general anesthesia. The induction of general anesthesia causes peripheral venous dilatation and reduction of venous return. It is not unusual to encounter cardiac arrest with the induction of anesthesia. Therefore, have the patient prepped and draped and the knife ready before anesthesia is induced, so that the chest can be opened immediately and the pericardium emptied without delay. Cardiac wounds often can be controlled with simple digital pressure; occasionally, a partial occlusion clamp is needed to control the bleeding. On several occasions, we have employed a Foley catheter, which is inserted through the cardiac rents. By inflating the Foley balloon and pulling it back, the bleeding may be tamponaded. Then an opportunity to repair the laceration is afforded. ◀

Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

Calf Pain in Rheumatoid Arthritis

Case Presentation

A 29-year-old black female was seen for calf pain. Three years earlier she had experienced onset of seropositive rheumatoid arthritis involving wrists, knees, ankles and small joints of hands and feet. Over the ensuing years she developed mild deformities and radiologic erosions consistent with her diagnosis. Several drug and physical therapy regimens had been prescribed with poor compliance and control. Present treatment included aspirin and penicillamine. Still disease remained active, particularly in her knees.

Seven days prior to admission, she noted aching in her left calf. Pain persisted and in three days she developed warmth, swelling and local tenderness. Walking became difficult. There was no past history of phlebitis. She had never used oral contraceptives and denied chest pain and hemoptysis.

Examination revealed vital signs to be normal. The patient exhibited swelling and deformity of joints in a pattern consistent with rheumatoid arthritis. Nodules were present behind the elbow. Both knees were warm and swollen with fluid present. The left calf was diffusely tender and warm without cords or edema. Homans sign was present. The right calf and both thighs appeared normal.

Laboratory

Hemoglobin was 11.6, hematocrit 37.7. White blood count was 6700 with a normal differential. SMA 18, EKG, urinalysis and coagulation profile were normal. Salicylate level was 21.4mg%. Chest X-ray was normal. Sedimentation rate (Westergren) was 55 mm/hr. Rheumatoid factor was 1:1280 by latex and 1:640 by sheep cell. Antinuclear antibodies were absent and serum complement levels were normal. Joint fluid from the left knee revealed cloudy fluid with 26,500

white cells and 80% polymorphs, absent crystals, negative gram stain and sterile cultures. X-rays of knees revealed minimal erosions consistent with rheumatoid arthritis. Arthrograph of left knee is seen in Figure 1.

Comment

Pseudothrombophlebitis¹ of the calf is a well recognized syndrome associated with popliteal (Bakers) cysts of arthritic knees. Cysts form as herniations of synovial lining into the popliteal fossa in response to elevated intra-articular pressure. Pain, tenderness and a positive Homans sign occur with dissection or rupture of cysts into the calf, mimicking thrombophlebitis. Symptoms occur secondary to soft tissue contact with inflammatory synovium or synovial fluid from the knee. Cords are absent. Pseudothrombophlebitis should be suspected when calf pain occurs in any rheumatoid arthritic, especially if active inflammation of the knee is present. Such patients have less tendency to develop thrombophlebitis because of the anticoagulant effect of salicylates. Other forms of inflammatory arthritis² or more rarely, degenerative arthritis, may occasionally underlie the syndrome.

Occasionally, especially when small and intact, Baker's cysts may exist as an asymptomatic fluid filled bulge behind the knee or in the calf. When large enough, the cyst may obstruct vessels³ or damage nerves⁴ leading to claudication, true thrombophlebitis or neuropathy. Similar cysts have been reported about elbows, wrists and shoulders.⁵

Arthrography is the diagnostic procedure of choice, revealing communications between knee, cyst and calf.⁶ Ultrasonography⁷ will reveal an intact cyst but may miss a ruptured one. The use of venous studies before other investigations depends on the physician's index of suspicion.



Figure 1

Arthrogram of left knee reveals a dissecting cyst (small arrows) which communicates with the knee. The cyst has ruptured and extravasated contrast material into the calf (large arrow).

Treatment is aimed at the cause of the cyst rather than the cyst itself. Intraarticular injections of corticosteroids as well as oral antiinflammatory agents will reduce inflammation at the knee and result in reabsorption of the cyst in the calf. Combined with leg elevation, such treatments are effective in the pseudothrombophlebitis syndrome. Rarely, when such treatment fails, synovectomy of the knee is required. Acute treatment of pseudothrombophlebitis should be simultaneous with treatment of the underlying arthritic condition.

Conclusion

Active inflammation in the knee and absence of cords in the calf suggested a ruptured Baker's cyst as the etiology of calf symptoms in a young patient with rheumatoid arthritis. An arthrogram was confirmatory. Treatment included intra-ar-

ticular steroids and leg elevation with significant improvement in both calf and knee. She was discharged to be continued on salicylates and penicillamine, and at four months has improved control of her rheumatoid arthritis without recurrence of calf symptoms. ◀

References

1. Katz, R. S., Zizic, T. M., Arnold, W. P., and Stevens, M. M.: "The Pseudothrombophlebitis Syndrome," *Medicine* (Baltimore) 56:151, 1977.
2. Weese, W. C., and McCarty, D. J.: "Spontaneous Rupture of the Knee Joint in Reiter's Syndrome," *JAMA* 208:825, 1969.
3. Schlenker, J. D., Johnston, H. and Wolkoff: "Occlusion of the Popliteal Artery Caused by Popliteal Cysts," *Surgery* 76:833, 1974.
4. Whalley, N.: "Compression of the External Popliteal Nerve by a Baker's Cyst," *Br. J. Surg.* 31:306, 1944.
5. Lane, F. W. F., Dyer, N. H. and Hawkins, C. F.: "Synovial Rupture of the Shoulder Joint," *Br. Med. J.* 1:356, 1972.
6. Wolfe, R. D. and Colloff, B.: "Popliteal Cysts: An Arthrographic Study and Review of the Literature," *J. Bone Joint Surg.* 54A:1057, 1972.
7. Moore, C. P., Sarti, D. A., Louie, J. S.: "Ultrasonographic Demonstration of Popliteal Cysts in Rheumatoid Arthritis: A Non-Invasive Technique," *Arthritis & Rheum.* 18:577, 1975.

Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

1979 Spring Course Schedule

- BASIC REVIEW IN PSYCHIATRY, March 12-16
- SPECIALTY REVIEW IN SURGERY, PART II, March 12-23
- CLINICAL MEDICINE UPDATE, March 19-23
- CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, March 30-31
- ADVANCES IN SURGERY, April 9-13
- SPECIALTY REVIEW IN UROLOGY, April 9-13
- STATE & NATIONAL BOARD REVIEWS
BASIC, April 16-22; CLINICAL, April 23-28
- RADIATION ONCOLOGY, April 23-27
- GENERAL & DIAGNOSTIC RADIOLOGY, April 23-27
- SPECIALTY REVIEW IN OB-GYN, April 30-May 11
- SPECIALTY REVIEW IN FAMILY PRACTICE, May 7-18
- SPECIALTY REVIEW IN ANESTHESIOLOGY, May 13-18
- REVIEW IN MEDICAL SUBSPECIALTIES, May 7, 14, 21
- SPECIALTY REVIEW IN PEDIATRIC CARDIOLOGY, May 23-25
- CARDIOLOGY FOR THE INTERNIST, June 7

For further information and course offerings, please write:

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Chicago Hosts AMA-RPS Interim Meeting

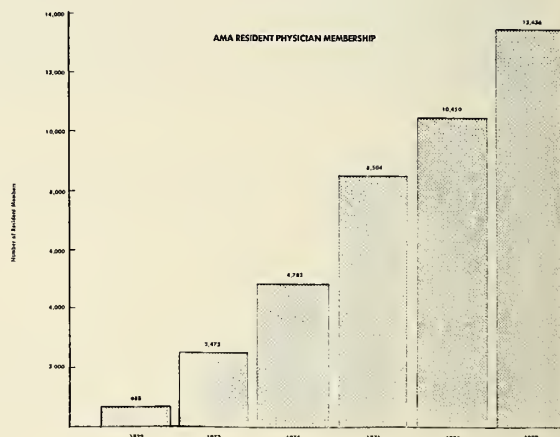
BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

The 1978 AMA-RPS Interim Meeting convened in Chicago on Dec. 1-2. On Dec. 1, mini-workshops were held on negotiations, financial management, legal issues, leadership development, cost effectiveness, physician well being, and organizational skills. The workshops were well attended and enthusiastically received. Illinois residents were impressed enough with the financial management seminar to initiate plans for the longer workshop to be presented at U. of I. and possibly at the ISMS annual meeting in Chicago. The financial skills management seminar included such useful information as how to distinguish high-quality disability insurance from expensive but useless policies and a simple formula for calculating the amount of life insurance an individual should carry after factoring for family, current income and possessions, and debts. Future presentations of this valuable seminar will be announced in this column.

Eight of the 58 RPS delegates were from Illinois. They were: Ira Isaacson, (N.U. ISMS-RPS Chairman), James DeBord (UI), Barry Lecompte (Rush Pres.-St. Luke's), Linda Hughey (UC), Stephen Cann (ISPI), James McCreary (UI), Brett Cassens (Ill. Masonic), and William Golden (Rush Pres.-St. Luke's).

This was the first AMA-RPS meeting to be attended by delegates from the armed services residency programs, but both the Army and the Air Force were well represented at this year's



meeting. Their participation added a valuable perspective to the resident assembly. Through the efforts of the armed services RPS delegates, a motion concerning the differences in Variable Incentive Pay (VIP) was considered by the RPS Assembly. This promises to be an area of ongoing concern. Civilian physicians often earn many thousands of dollars yearly in "VIP" while physicians who are trained in the armed services are not always eligible for this differential. Small wonder that the armed services are lacking in career

physicians. The issue of variable incentive pay is very important to residents in the armed services, and AMA-RPS investigation may be of help to the armed service residents.

The AMA-RPS Interim Meeting was topped off by a cocktail reception hosted by the ISMS-RPS in the ISMS suite. This was attended by many resident delegates as well as a number of ISMS members from the AMA delegation. The congeniality among residents and ISMS regular membership has always marked Illinois and made the Illinois RPS a model for other state resident groups. As other states develop similar working relationships with their residents, the RPS membership at a national level should continue to grow. (See accompanying graph.)

Dr. DeBord Reports from AMA Council on Scientific Affairs

Dr. James DeBord, a resident in surgery at the University of Illinois and the resident member on the AMA Council on Scientific Affairs, reported on the Council's activities at the Interim Meeting. The Council investigates scientific matters which are of concern to physicians and re-

ports back to the AMA House of Delegates and Board of Trustees. At the most recent Council meeting, eleven reports were submitted to the AMA, including reports on a recently developed "manual for staging cancer, 1977," the means of obtaining Human Growth Hormone, a set of guidelines for diagnosis and treatment of alcoholism, and medical care facilities for the chronically ill. The RPS had requested an investigation of the effects of herbicide use, particularly paraquat, on marijuana plants, and the Council will receive background material on this subject at their next meeting. By a slim majority, the council endorsed the recommendations of the National Commission on Smoking and Public Policy.

The RPS has seats on most of the major AMA Councils. The Councils generally meet four or five times a year, and most residents have found that the experience of sitting on a national committee with national movers and shakers in medicine far outweighs the inconvenience of getting to the meetings. Information on the various positions may be obtained from the AMA Dept. of House Staff Affairs, 535 N. Dearborn, Chicago, Ill. 60610.

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Medicare Workshops Announced

Electronic Data Systems Federal Corporation (EDS Federal) will become Part B Carrier for Medicare in Illinois as of April 1, 1979, for Cook County and as of July 1, 1979, for all other Illinois counties. In cooperation with ISMS, they have planned a series of educational workshops for physicians, physician office personnel, medical assistants, clinic managers and others processing Medicare claims. Further information will be mailed to ISMS members, but the schedule below may facilitate scheduling attendance.

Approved Initial EDS Federal Workshops—Cook County

<i>Date</i>	<i>City</i>	<i>Location</i>
March 7	Arlington Heights	Arlington Park Hilton
March 21	Oak Lawn	Sheraton Motor Inn
March 28	Chicago	Holiday Inn Mart
March 29	Chicago	Holiday Inn Mart

Initial Workshops Outside of Cook County

<i>Date</i>	<i>City</i>	<i>County</i>	<i>Location</i>
May 30	Rock Island	Rock Island	Moline Public Hospital
June 6	Glen Ellyn	DuPage	Holiday Inn
June 7	Waukegan	Lake	Sheraton
June 12	Peoria	Peoria	Ramada
June 13	Glen Ellyn	DuPage	Holiday Inn
June 14	Joliet	Will/Grundy	Holiday Inn
June 19	St. Charles	Kane	Ramada
June 20	Rockford	Winnebago	Clock Tower
June 26	Belleville	St. Clair	Augustine's
June 26	Mt. Vernon	Jefferson	Holiday Inn
June 27	Springfield	Sangamon	Sheraton
June 28	Champaign	Champaign	Ramada

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

CARBONDALE: G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

CHICAGO: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

FAIRFIELD: Population 6,500. Opening for OB-Gyn board eligible or certified and general practitioner to join group of two physicians (F.P. and surgeon). Complete office facilities, excellent salary and fringe benefits, opportunity to become full partner. Near university, junior college locally. Good fishing, hunting, cultural opportunities, all churches. Contact: S. W. Konarski, M.D., 401 East Center Street, Fairfield 62837. (618) 842-2187. (3)

HARVARD: An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

ILLINOIS: The Illinois Dept. of Corrections has immediate openings statewide for Family Practice or General Practice Physicians interested in ambulatory care. For additional information and salary schedule contact: Cecil Patmon, 160 N. LaSalle, Chicago, 60601, 312/793-3216. (6)

JACKSONVILLE: Opportunities for family practice, emergency room, dermatology, OB/GYN, orthopedic surgery. Progressive 250 bed hospital, 40-member medical staff. Prosperous community with primary service area of 60,000, two colleges, excellent schools, 35 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Area Hospital, Jacksonville, 62650 (217) 245-9541. (6)

LA GRANGE: Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

MACOMB: GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

MATTOON: American trained family practitioner or internist for rewarding practice. Fully equipped office available—new 210 bed hospital (open staff)—financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient population of 75,000. Contact: A. Rauwolf, M.D., 1120 Wabash, Mattoon 61938. (217) 234-6253. (4)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity in solo or group practice. Contact: Carol Nafziger, Minier 61759. (309) 392-2345 or 392-2120. (6)

MUNSTER, IN.: Family, ENT, Ortho.; for large mid-west multi-specialty group. Competitive first year salary with opportunity for early partnership. No investment. Most liberal vacation and P-G allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop own practice. Send C-V to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321 (219) 836-5800. (6)

PEORIA: Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702). (3)

PEORIA: Orthopedic Surgeon needed in multispecialty clinic of 12 physicians. Excellent opportunity for the right person. Located in community of 250,000, three hospitals, school of medicine. Guaranteed first year salary plus complete fringe package. Contact: Dr. R. Martin, The Medical and Surgical Clinic, S.C. 100 N. E. Randolph, Peoria, 61606. (6)

PIKE COUNTY: Population 19,000. Two general practitioners, one general surgeon, office space available

beside 82 bed, JCAH, full service hospital. Financial assistance available. Ten physicians at present. Great hunting. Gary Deer, Administrator, Illini Community Hospital, 640 West Washington, Pittsfield, AC(217) 285-2113. (6)

VALMEYER: Population 1000 with patient population of 3-4000. Scenic town on small lake. 25 miles from Belleville or Red Bud, 35 miles from St. Louis, Mo. Only physician is about to retire. Fully equipped 4 room office building for rent. Contact: H. A. Reichel, M.D., 206 W. Main, Valmeyer Il 62295. (618) 935-2216. (6)

WEST FRANKFORT: Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)

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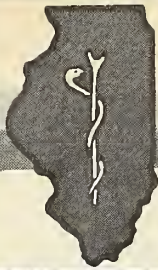
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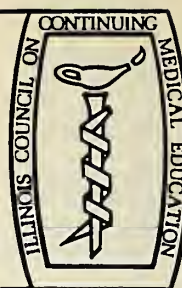
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

MARCH

Family Medicine

Clinical Medicine Update

For: GP's, FP's. Lecture, March 19 (5 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Boker, MD. Phone: 312-733-2800.

Internal Medicine

Clinical & Laboratory Diagnosis of Hemorrhagic & Thrombotic Disorders

For: Clinical Pathologists, Internists, Hematologists, Laboratory Managers. Lecture, March 30 (2 days), Chicago. Speaker: Hou Kwaan, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$150. Reg. limit: 100. Credit: AMA Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Pathology & Medical Lab Services

Seminar on Pathology and Medical Laboratory Standards

For: Pathologists, Medical Technologists, Technicians, Clinical Scientists. Seminar March 30, 8:30-4:00 p.m., Ambassador West Hotel, Chicago. Sponsor: JCAH, 875 N. Michigan Ave., Chicago 60611. Reg. deadline: March 23. Fee: \$125. Reg. limit: none. Credit: AMA Category 1, 7 1/2 hours. Contact: Felix Liddell. Phone: 312-642-6061.

Patient Care Evaluation

Audit Clinic

For: MD's, Nurses, Medical Records Professionals. Seminar, March 15-16, 8:30-4:30 p.m., Ambassador West Hotel, Chicago. Reg. deadline: March 7. Fee: \$185. Reg. limit: none. Credit: AMA Category 1, 12 hours. Sponsor: Illinois League for Nursing, 59 E. Van Buren, Chicago 60605. Contact: Felix Liddell. Phone: 312-642-6061.

Psychiatry

Pharmacologic Treatment of Mental Illness

For: Psychiatrists, MD's. Symposium, March 16-17, Center for Continuing Education, Chicago. Sponsor: The University of Chicago Department of Psychiatry, 950 E. 59th St., Chicago. Fee: \$150. Credit: AMA Category 1, 14 hours. Contact: Toby Lou Hofslund. Phone: 312-753-3189.

Basic Review in Psychiatry

For: Psychiatrists, Neurologists. Lecture, March 12 (5 days), Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Surgery

Specialty Review in Surgery, Part II

For: General & Specializing Surgeons. Lecture, beginning March 12, Chicago. Speaker: Robert Boker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$425. Reg. limit: 300. Credit: AMA Category 1, 99 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

APRIL

Basic Audit Seminar

Basic Audit Seminar/Psychiatric Audit Team Seminar
For: Medical & Mental Health Professionals. Seminars, April 4-5, Ambassador West Hotel, Chicago. Sponsor: JCAH, 875 N. Michigan Ave., Chicago 60611. Reg. deadline: March 29. Fee: \$165. Credit: AMA Category 1, 13 1/2 hours; AMRA, 13. Contact: Felix Liddell. Phone: 312-642-6061.

Family Medicine

31st Annual Postgraduate Seminar

For: FP's. Lectures/Seminars, Hyatt Regency, Chicago. Sponsor: Illinois Academy of Family Physicians, 1200 Harger Rd., Ste. 405, Oak Brook 60521. Fee: members, none; others, \$25. Reg. limit: none. Credit: AMA Category 1, 16/22 hours; AAFP Prescribed, 16/22 hours. Contact: H. Morchmont Robinson, MD. Phone: 312-325-8502.

Internal Medicine

State & National Board Review, Basic
For: MD's. Lecture, April 16 (6 1/2 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 150. Credit: AMA Category 1, 58 hours. Contact: Robert Boker, MD. Phone: 312-733-2800.

State & National Board Review, Clinical
For: MD's. Lecture, April 23 (6 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$250. Reg. limit: 150. Credit: AMA Category 1, 53 hours. Contact: Robert Boker, MD. Phone: 312-733-2800.

Thrombophlebitis-Peripheral Vascular Disease

For: MD's, RN's. Symposium, April 18, 7:00 p.m., Effingham. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

Fourth Annual Postgraduate Course on Gastroenterology

For: MD's. Symposium, April 5, 8:00 a.m.-5:30 p.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Credit: AMA Category 1, 8 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Obstetrics & Gynecology

Specialty Review in Obstetrics & Gynecology

For: Obstetricians, Gynecologists. Lecture, April 30 (10 1/2 days), Chicago. Speaker: John Mosterson, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$400. Reg. limit: 200. Credit: AMA Category 1, 83 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Pediatrics

Pediatric Symposium

For: MD's, RN's. Symposium, April 7-8, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Psychiatry

Midwest Conference on Psychiatric Care
For: MD's, RN's, social workers. Symposium, April 5-6, 8:00 a.m.-4:30 p.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Credit: AMA Category 1, 15 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Radiology

Radiation Oncology

For: Radiologists, Oncologists. Lecture, April 23 (5 days), Chicago. Speaker: Walid Hindo, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 75. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Surgery

Burn Management Symposium

For: MD's, RN's. Symposium, April 4, 8:00 a.m.-5:00 p.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Credit: AMA Category 1, 6 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Advances in Surgery

For: General/Specializing Surgeons. Lecture, April 9 (5 days), Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Urology

Specialty Review in Urology

For: Urologists. Lecture, April 9 (5 days), Chicago. Speakers: Thomas John, MD, Irving Bush, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

MAY

Anesthesiology

Specialty Review in Anesthesiology

For: Anesthesiologists. Lecture, May 13 (6 days), Chicago. Speaker: Alon Winnie, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 300. Credit: AMA Category 1, 54 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Cardiac Rehabilitation

Illinois Heart Association's Annual Scientific Session

For: MD's, RN's. Case studies/lecture, May 10-11, Ramada Inn, Champaign. Sponsor: Illinois Heart Association, 1181 N. Dirksen Pkwy., P.O. Box 2666, Springfield 62708. Cosponsor: American Heart Association Council on Clinical Cardiology. Reg. deadline: May 8. Fee: \$45. Reg. limit: 300. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours. Contact: A. Paul Naney, MD. Phone: 217-525-1350.

Complications in Anesthesia

Sixteenth Midwest Anesthesiology Conference

For: MD's, RN's, students, residents. Symposium/lecture, May 10-12, Chicago. Sponsor: Illinois Society of Anesthesiologists, Division of CME, 2160 S. First Ave., Maywood 60153. Fee: \$100; n/c for ISA members. Credit: AMA Category 1. Contact: Linda Gunzburger. Phone: 312-531-3236.

Emergency Room Trauma

Midwest Spring Conference

For: MD's, RN's, paramedics. Seminar, May 16-17, Sheraton Motor Lodge, Rock Island. Sponsor: Moline Public Hospital, 635 10th Ave., Moline 61265. Reg. deadline: April 20. Fee: \$60. Reg. limit: 400. Contact: Diane Lovett, RN. Phone: 815-762-3651 x 355.

Family Medicine

Specialty Review Course in Family Practice

For: FP's, GP's. Lecture, May 7 (11 days), Chicago. Speaker: Harry Marchmont Robinson, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$400. Reg. limit: 200. Credit: AMA Category 1, 98 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Forensic Medicine

Review of Current Forensic Pathology Cases

For: MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, IL, 1828 W. Polk St., Chicago 60612. Fee: none. Reg. limit: 50. Contact: Robert Stein, MD. Phone: 312-443-5017.

Internal Medicine

Advances in Internal Medicine

For: Internists. Lecture, May 21-25, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$275. Reg. limit: 500. Credit: AMA Category 1, 35 hours; AAFP Prescribed, 35 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Specialty Review in Cardiovascular Disease

For: Cardiologists, Internists. Lecture, May 21, Chicago. Speaker: John Demakis, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Specialty Review in Medical Oncology

For: Oncologists, Internists. Lecture, May 21 (5 days), Chicago. Speaker: William DeWys, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

THIRD ILLINOIS HEALTH CARE RESEARCH SYMPOSIUM March 12-13, 1979 Continental Plaza Hotel Chicago

For further information contact: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Phone: 312-996-8025.

Specialty Review in Endocrinology

For: Endocrinologists, Internists. Lecture, May 14 (5 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Specialty Review in Gastroenterology

For: Gastroenterologists, Internists. Lecture, May 7 (5 days), Chicago. Speaker: Ruven Levitan, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Medicine

Human Values in Health Care

For: MD's, clergy, health professionals. Lecture/workshop, May 8 or 9, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$50. Reg. limit: 500. Credit: AMA Category 1, 7 hours; AAFP Prescribed, 7 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Musculoskeletal Trauma

Clinical Hospital Program on Musculoskeletal Trauma

For: MD's. Lecture, May 10, 8:00 p.m., John B. Murphy Auditorium, Chicago. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, c/o 11255 W. 74th St., LaGrange 60525. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Husa.

Neurology

Neuromuscular Diseases

For: MD's. Symposium, May 10-12, St. Louis, Missouri. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri. Cosponsor: Muscular Dystrophy Association. Fee: \$200. Reg. limit: 200. Credit: AMA Category 1, 18 hours; AAFP Elective, 18 hours. Contact: Loretta Giacometti. Phone: 314-454-3873.

Nuclear Radiology

Nuclear Radiology Workshop

For: MD's, Radiologists, Technologists. Workshop, May 4-5, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$150. Reg. limit: none. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

SAVE THE DATE

1979 ANNUAL CONGRESS ON CME

April 6-7

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in the affairs of government
is to live under the government
of unwise men."*

Sir Edmund Burke

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Doctor's News

FAS PROGRAM ANNOUNCED—The ISMS Board of Trustees recently voted to co-sponsor a program on the fetal alcohol syndrome scheduled for June 18, 1979 at the Sheraton-O'Hare. The program, developed by the Fetal Alcohol Syndrome Work Group, is co-sponsored by the Governor's Planning Council on Developmental Disabilities, Governor's Citizens Advisory Council on Alcoholism, and Illinois Nurses Association. The workshop will include comment from national experts in the field, and is intended to explore clinical alternatives and share recent research data. For further information write the IDMHDD Division of Alcoholism at 188 W. Randolph, Chicago 60601, or call (312) 793-2907.

MARCH IS MENTAL RETARDATION MONTH—The Association for Retarded Citizens will observe Mental Retardation Month in March, and has asked for citizen support through contributions of both time and money, as well as understanding and acceptance of mentally retarded people. For further information, write their national headquarters, 2709 Avenue E East, Arlington, TX 76011.

PEDIATRICIANS SCHEDULE ANNUAL CONFERENCE—The Illinois Chapter of the American Academy of Pediatrics will hold its 3rd Annual Conference, April 27-29, 1979, at the Arlington Heights Hilton. Dr. Eugene F. Diamond, Illinois Chapter president and program chairman, has announced that the three-day session will feature lectures, panel discussions and general presentations on various aspects of pediatrics. For further information, please contact Jean Althoff, at the Chapter's offices, 55 East Monroe, Suite 3510, Chicago, IL 60603 (312-782-1654).

THE DYNAMICS OF CONFLICT RESOLUTION are the subject of a series of AMA seminars for physicians and medical society staff scheduled for March 28-April 1 in Chicago. The educational programs are designed to inculcate an understanding of the process, procedure, skills and strategies of negotiating. Registration fee to member physicians is \$300. For further information contact the AMA Department of Negotiations, 535 N. Dearborn, Chicago 60610, (312) 751-6647, attn. Ike Mayeda.

SPORTSMEDICINE CONFERENCE ANNOUNCED—The Ninth Annual Great Plains Sports Medicine Conference is scheduled for Friday, March 30 and Saturday, March 31, at the Peoria Hilton Hotel. Co-sponsored by the Great Plains Sports Medicine Foundation and the St. Francis Hospital Medical Center in Peoria, the conference is open to all interested physicians. For registration information, contact: Jeff Sunderlin, Conference Coordinator, 624 N. E. Glen Oak Ave., Peoria, IL 61603, (309) 672-2386.

RECENT APPOINTMENTS—The Blackhawk Area Medical Association has announced that G.H. Steve Wilson has succeeded Johanna Lund in the position of Executive Vice President. The Blackhawk Area Medical Association encompasses the Winnebago County Medical Society, Blackhawk Area Individual Practice Association and the Northern Illinois Foundation for Medical Care. . . . Clarence N. Peiss, Ph.D., has been named dean for the Loyola University Stritch School of Medicine.

PHYSICIANS IN THE NEWS—Joseph Interlandi, M.D., Broadview, was recently elected to serve as president of the Society for Clinical Ecology. . . . New president of the St. Joseph Hospital medical staff in Chicago is **Hugh Gavin Grimes, M.D.**, of Wilmette. Dr. Grimes is also an assistant professor of OBGYN at the Loyola University Stritch School of Medicine. . . . **William T. Meszaros, M.D.**, Chicago, has been elected president of the Radiological Society of North America. Doctor Meszaros has served as a professor of radiology for the University of Illinois Medical Center since 1974. . . . **Abdul Razzaq, M.D.**, Granite City, was recently named a fellow of the American College of Chest Physicians.

The UI Abraham Lincoln School of Medicine has named **William N. Spellacy, M.D.**, Chicago, chairman of their department of OBGYN. . . . **Morton C. Creditor, M.D.**, was recently named acting executive dean for the UI College of Medicine in Chicago. Dr. Creditor is the former associate dean of the UI School of Clinical Medicine at Urbana-Champaign.

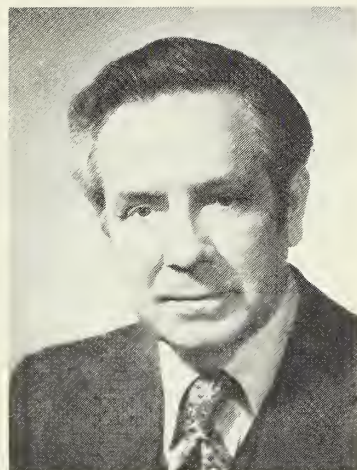
Ten Illinois physicians were recently awarded fellowships in the American College of Cardiology. Those honored were: **Firouz Amirparviz, M.D.**, Oak Brook, **Joseph Askenazi, M.D.**, Chicago, **Cary E. Berkowitz, M.D.**, Glenview, **David H. Davis, M.D.**, Aurora, **Ming H. Hwang, M.D.**, Hines, **Jay H. Kleiman, M.D.**, Chicago, **Jerrold E. Shapiro, M.D.**, Chicago, **Richard Snodgrass, M.D.**, Moline, **Chaihan Ungbhakorn, M.D.**, Peoria and **Donald D. Wilson, M.D.**, Rockford.

PHERESIS PRODUCTS PAMPHLET AVAILABLE—The Missouri-Illinois Region of the American Red Cross Blood Services has published a pamphlet for physicians interested in obtaining pheresis products. The pamphlet addresses indications and dosages as well as donor selection, transfusion and crossmatch testing. Further information may be obtained by writing: Missouri-Illinois Region, American Red Cross Blood Services, c/o Pheresis Department, 4050 Lindell Blvd., St. Louis, MO 63108.

RURAL OBSTETRICS HERALDED—The American Medical Association recently reported the results of a study by Herman A. Hein, M.D., of the University of Iowa Hospitals and Clinics comparing the quality of urban versus rural hospital obstetrical care. The study determined that small rural hospitals are entirely safe and in fact less costly in delivering babies, because high risk expectant mothers are screened and sent to specialized urban centers. This report refuted a statement by federal health planners that hospitals delivering less than 500 infants annually lacked quality and efficiency. "The future of small community hospitals," Dr. Hein said, "should be determined on the basis of available data rather than on speculation." (The study is reported in detail in the November 3, 1978, issue of JAMA)

RESOLUTIONS DEADLINE—The ISMS Annual Meeting is scheduled for May 6-9, 1979, at the Chicago Palmer House. Resolutions for the House of Delegates must be *received* in the ISMS offices by April 8, 1979. Resolutions received after that date will be considered late resolutions and require special action for possible consideration.

In accordance with a resolution passed at the 1978 Annual Meeting, resolutions will be published in the *Journal* by author and subject only. In order to be published in the *Journal*, resolutions must be *received* in the ISMS offices by an earlier deadline, March 4.



The Commitment

Our profession frequently is chastized for failure to "police" physicians. It is frustrating when we also are criticized for efforts to insure strong disciplinary action.

That has been the case with ISMS' drive to bring the operation of the state Medical Disciplinary Board into compliance with the Medical Practice Act. This struggle involves the Department of Registration and Education (R&E) which steadfastly has refused to allow the Board to function according to either the intent or letter of the statute.

The Board has clearly-defined authority to serve as both the investigator and hearing body in discipline proceedings. R&E disputes this statutory mandate, claiming that to combine the two functions would violate due process. As a result, the investigative activities have been assigned to a medical coordinator, and the Board's authority has been usurped.

The ineffectiveness of this approach was dramatically underscored by the recent Chicago abortion clinic scandal. Complaints had been lodged with R&E years earlier against several physicians prominently linked to the clinics. R&E simply failed to follow up.

By splitting the line of authority, R&E has "tied the hands" of the Board. In many instances, the medical coordinator has investigated a complaint . . . allowed—in conjunction with R&E's legal staff—the physician to voluntarily surrender his license for a specific period . . . or closed the case without any action. What was the role of the Board? It merely was informed of the coordinator's decision.

ISMS' concern over this situation—and other practices which contradict the statutes—resulted in the so-called "secret meeting" last July between ISMS officers and the Board. Society representatives appeared at a regularly-scheduled Board meeting. Upon advice of R&E legal counsel, the Board did not allow the media to witness the ISMS testimony. This led to charges that the Illinois Open Meetings Act was violated . . . and that ISMS had requested the meeting to complain that doctors were being disciplined too harshly.

Six months after that meeting, the Society still is being accused of advocating a "go easy" approach to doctor discipline. I assure you, the opposite is true. ISMS never has wavered from its commitment to rid the profession of those who pose a threat to the public.

That commitment was evidenced by our role in securing passage of legislation that created the current disciplinary system. It will be further evidenced by our continuing drive to correct practices which violate the statutes and cripple the system. ◀

A handwritten signature in dark ink, reading "David S. Fox".

David S. Fox, M.D., President

Guest Editorial

AMA Is Active In Effort To Cut Federal Regulation Down To Size

To what extent does glamorized federal planning boil down to sheer regulation? And to what extent does the regulation lead to costly irregularities?

These are questions with which the American Medical Association must constantly grapple, in numerous situations and respects. And various irregularities have been cited by units of the government itself—alongside the pressure for a greater federal role in health.

Consider these examples:

- Legislation has been introduced in Congress—by Rep. Tim Lee Carter, a physician—to keep Food and Drug Administration regulations from overly delaying the approval of new drugs that could benefit patients both medically and economically.

- The General Accounting Office—federal budgetary watchdog—has complained that HEW-funded neighborhood health centers are not reaching most of America's medically underserved, and that HEW has not made sure the centers are put in the neediest areas.

- The GAO has also complained of defects in HEW's Health Maintenance Organization program, including an "ineffective" record in administering and monitoring the loans for HMOs.

- A number of local Health Systems Agencies under the Health Planning Act have protested HEW's guidelines for implementing the act—partly on the ground that these supersede, and thus duplicate in cost, the guidelines that HSAs have been developing.

HEW, according to a recent Associated Press story, misspent more than \$5 billion in fiscal 1977 and blames waste and mismanagement more than fraud and abuse.

Yet, does that estimate—whopping as it is—give the full picture of health expenditure gone astray? What about the cost of supplanting those HSA guidelines? And what about the \$5,000 to \$20,000 (depending on the project involved)

that applicants for a certificate of need must spend on its processing under the Health Planning Act?

In health and other fields, "the sum of the administrative costs of federal regulation (paid by the taxpayer) and the compliance costs (generally passed on to the consumer in the form of higher prices) may top \$100 billion" for fiscal 1979, says Murray L. Weidenbaum, director of the Center for the Study of American Business at Washington University, St. Louis, and a former federal official.

That \$100 billion is where supposedly idealistic planning can lead.

Well, what are some of the things the AMA has been doing about the examples and problems given above?

- The AMA developed the anti-drug-delay bill introduced by Kentucky Congressman Carter.

- It is a cosponsor of a Robert Wood Johnson program to improve medical services in the inner cities of Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose.

- The AMA House of Delegates in June approved "in principle" a National Commission on the Cost of Medical Care recommendation calling in part for "fair market competition between HMOs and other provider and insurance systems."

- The AMA supports Health Planning Act amendments to make HSAs more independent in their guidelines and operations.

- It backs the proposed Sunset Act that would require regulatory agencies and programs to justify their right to eternity and make them more accountable to Congress.

The Association is so energetic in so many areas of activity that some physicians may be confused as to just what it does. But the \$250 regular dues are spent as soundly and effectively as possible for the benefit of all physicians and patients—and every doctor should know. ◀

AMA



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Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

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Adverse Reactions

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Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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NIM-3

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Obituaries

***Francona, Anthony**, Chicago, died December 29, 1978, at the age of 68. Dr. Francona was a 1934 University of Illinois graduate.

****Ladd, Robert L.**, Chicago, died November 11, 1978, at the age of 81. Dr. Ladd was a 1927 graduate of Rush Medical College. He had served on the staffs of Washington Boulevard and Wesley Memorial Hospitals between 1927 and 1969.

***Klien, Bertha Anna**, Chicago, died December 28, 1978, at the age of 80. Dr. Klien was a 1925 graduate of the University of Vienna, Austria. In 1959 she became a full professor at the University of Chicago. She was a national president of the Pathology Club and also the Society of Ophthalmology in Chicago.

***Krainer, Leo**, Chicago, died December 12, 1978, at the age of 71. Dr. Krainer was a 1931 medical school graduate from Wein, Germany.

***Mirmelli, Edward J.**, Chicago, died December 10, 1978, at the age of 68. Dr. Mirmelli was a 1937 graduate from Rome, Italy.

***Moles, Joseph B.**, Oak Park, died December 18, 1978, at the age of 57. Dr. Moles was a 1948 University of Illinois graduate.

****Neff, Emery B.**, Rock Island, died December 19, 1978, at the age of 88. Dr. Neff was a 1912 University of Illinois graduate.

***Reid, H. Gordon**, Chicago, died October 30, 1978, at the age of 78. Dr. Reid was a 1924 graduate from Canada.

***Roberson, Brooks L.**, Wood River, died December 18, 1978, at the age of 73. Dr. Roberson was a 1930 graduate of the University of Illinois Medical College. He was one of the founders of Wood River Township Hospital.

****Tichy, Ladislav Sala**, Chicago, died December 10, 1978, at the age of 84. Dr. Tichy was a 1918 graduate of Loyola University Stritch School of Medicine.

***White, William S.**, Springfield, died December 13, 1978, at the age of 60. Dr. White was a 1943 graduate of the University of Toronto. He was certified by the American Board of Urology and an active staff member of Memorial Medical Center, St. John's Hospital and Springfield Community Hospital.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.



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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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Special Article

Diagnosis of Infant Botulism

The Illinois Department of Public Health has forwarded the following information for the benefit of Illinois physicians. The cover letter, from Andrew M. Wiesenthal, M.D., IDPH medical epidemiologist, reads in part: "We feel that there is a need to foster increased awareness of this disease by all physicians in Illinois and particularly by those physicians taking care of children and children's neurological problems. By increasing the awareness in the providers of care, we hope to increase reporting of infant botulism to the Illinois Department of Public Health and thereby to the Center for Disease Control."

Infant Botulism was first reported in California in 1975, and, as of early 1978, a total of 58 cases had been reported from throughout the country. Cases have been reported from 15 states of varying geographic regions and sizes (none from Illinois), and the number of cases reported has increased as physician awareness of the syndrome has increased.

The disease is characterized clinically by initial constipation followed by progressive neuromuscular deterioration—poor feeding, pooling of oral secretions, weak cry, and loss of head control. Respiratory insufficiency can occur.

The pathogenesis of infant botulism is of interest because it is felt to be secondary to *in vivo* botulinal toxin elaboration after multiplication of *Clostridium botulinum* in the infant's gut. Why this may occur in some infants (it is known not to occur in adults) is not clear.

Therapy is supportive only. Neither botulinal antitoxin nor antibiotics have been shown to be effective, and there are theoretical reasons to assume that antibiotics may be detrimental.

The differential diagnosis is rather extensive and includes sepsis, failure to thrive, myasthenia gravis, poliomyelitis, meningitis, and encephalitis from all causes, and a variety of hereditary and metabolic diseases. In infant botulism, the patient is usually afebrile and alert and has a normal sensory examination. Cerebrospinal fluid, nerve conduction tests, and tensilon test should all be within normal limits. Confirmation of the diagnosis requires the demonstration of the toxin or

the organism, or both, in the feces of the infant (where both can persist for many weeks) and possibly in serum. Information regarding collection and submission of diagnostic specimens can be obtained from the Illinois Department of Public Health laboratory, 2121 West Taylor, Chicago, Illinois 60612, telephone 312/793-4744.

The Illinois Department of Public Health and the Center for Disease Control of the United States Public Health Service are interested in improving Illinois surveillance for infant botulism. Suspect cases should be reported by telephone to the Illinois Department of Public Health, Division of Disease Control, Springfield (telephone 217/782-2016). Clinical consultations can also be obtained through the same division.

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(Continued from page 76)

Answers: 1. C 2. E

The lead I, II, III rhythm strip demonstrates a tachycardia at a rate of 130 beats/minute with narrow QRS complexes. No distinct P waves can be seen. This is a paroxysmal supraventricular, or reciprocating tachycardia. The last RR cycle of the tachycardia is slightly longer than those RR cycles to the left of the baseline artifact. This is relatively common in those tachycardia that are on the electro-physiological basis of reentry. It is as if the last beat of the tachycardia prior to conversion to sinus rhythm has a difficult time negotiating the reentry or circus tract. Once sinus rhythm develops, in the last six beats of the strip, the small Q waves in leads II and III disappear suggesting they represented aberration. Most studies in the literature find cardiac arrhythmias common in patients with mitral valve prolapse: Recorded incidences for various arrhythmias are: premature ventricular beats 45%, premature atrial beats 55%, ventricular tachy-

cardia 6.3%, and paroxysmal atrial tachycardia 6.1%. Sudden death has been reported in 1.4% of these patients. The mitral valve prolapse seems to be more common in women. In a series of 1169 asymptomatic women, average age 32 years, it was found in 6.3%. Most patients in the literature are symptomatic and come for an examination because of palpitations or chest pains. While Holter ambulatory ECG monitoring is good for detecting cardiac arrhythmias, the echocardiogram will demonstrate the mitral valve prolapse. At Loyola, we had an opportunity to study 17 patients with His bundle recordings and pacing. Reentry could be demonstrated in 12 of these 17 patients. Propranolol is recommended as the treatment of choice in these arrhythmias. In our patient, 80 mg. of Propranolol per day allowed her to become asymptomatic. For further reading, see M. H. Swartz, et al., *American Journal of Medicine*, 62:377-389, March, 1977.

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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

Clinics for Crippled Children Listed for April

Thirty-six clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 26 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- April 3 Quincy—Blessing Hospital
- April 3 Belleville—St. Elizabeth's Hospital
- April 3 Park Ridge Cardiac—Lutheran General Hospital
- April 4 Aurora (MM)—Mercy Center for Health Care Services
- April 4 Hinsdale—Hinsdale Sanitarium
- April 4 Cairo—Public Health Department
- April 5 Sterling—Community General Hospital
- April 5 Effingham—St. Anthony Memorial Hospital
- April 5 Lake County Cardiac—Victory Memorial Hospital
- April 6 Division Cardiac—U. of I. at the Medical Center
- April 9 Peoria Cardiac—St. Francis Hospital
- April 10 East St. Louis—Christian Welfare Hospital
- April 10 Peoria General—St. Francis Hospital
- April 11 Champaign-Urbana—McKinley Hospital
- April 11 Joliet—St. Joseph's Hospital
- April 11 Rockford—St. Anthony's Hospital
- April 12 Springfield General—St. John's Hospital
- April 12 Kankakee General—St. Mary's Hospital
- April 16 Maywood—Loyola Medical Center
- April 17 Decatur—Decatur Memorial Hospital
- April 17 Rock Island General—Moline Public Hospital
- April 18 Metropolis—Massac Memorial Hospital
- April 18 Springfield Ped-Neuro—St. John's Hospital
- April 18 Centralia—St. Mary's Hospital
- April 18 Aurora—Mercy Center for Health Care Services
- April 18 Chicago Heights General—St. James Hospital
- April 19 Bloomington—Mennonite Hospital
- April 19 Litchfield—St. Francis Hospital
- April 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
- April 19 Rockford—Rockford Memorial Hospital
- April 20 Kankakee Cardiac—St. Mary's Hospital
- April 20 Chicago Heights Cardiac—St. James Hospital
- April 23 Peoria Cardiac—St. Francis Hospital
- April 24 Peoria General—St. Francis Hospital
- April 27 Chicago Heights Cardiac—St. James Hospital
- April 27 Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

for March, 1979

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.
Manati, Puerto Rico 00701



In treating certain G.I. disorders...
Enhance your therapeutic expectations
with the triple benefits of

Adjunctive
Librax
antianxiety/antisecretory/antispasmodic

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

Librax is unique among G.I. medications
in providing the specific antianxiety action of
LIBRIUM® (chlordiazepoxide HCl) as well as the potent
antisecretory and antispasmodic actions of
QUARZAN® (clidinium Br) for adjunctive therapy
of irritable bowel syndrome* and duodenal ulcer.*



*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

Abstracts of Board Actions

January 27, 1979

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Special Malpractice Court

ISMS endorsed in principle continuation of the special medical malpractice section of the Cook County Circuit Court . . . and urged ISMS to create a coalition—of representatives from the Society of Trial Lawyers and those companies underwriting physicians' professional liability insurance—to meet with Chief Judge Harry Comerford in an effort to convince him of the need to continue the special section. Shortly after his election last fall as chief judge, Comerford eliminated the special section and turned its functions over to the law division, which already has a 46,000 case backlog. The move threatens to neutralize progress made in dealing with malpractice litigation in an expeditious and equitable manner. The court's special malpractice section had been supervised by the now-retired Judge David Canel.

'79 Budget

The Board approved a 1979 ISMS balanced budget based upon anticipated income and expense of \$2,182,083. The Board also:

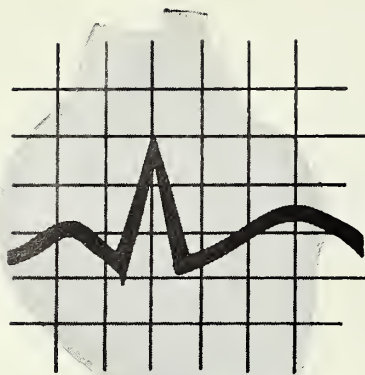
- Approved a 1979 Benevolence budget of \$135,450 income and \$45,000 expenses.
- Approved a 1979 ICCME expense budget of \$206,376, with expenses not to exceed income by more than \$54,426 without additional contributions from ISMS. Total ISMS contributions to ICCME were estimated to be \$132,500.
- Voted to recommend that the House of Delegates not adopt Resolution 78N-43 which would require distribution of information and resolutions involving ISMS dues and assessments to delegates and county societies at least 30 days prior to House consideration. While supporting the principle of the resolution and agreeing that everything possible should be done to comply with its intent, the Board noted that unforeseen circumstances could prevent its implementation. (The House had referred Resolution 78N-43 to the Board for study.)

Medicaid

ISMS representatives will meet Feb. 13 in Washington with HEW legal staff to discuss major problems involving confidentiality of Medicaid patient records. The meeting is part of an ongoing ISMS effort to prohibit the Ill. Dept. of Public Aid (IDPA) from demanding patient records during Medicaid audits without first obtaining patient consent. IDPA maintains that the physician is obligated to surrender the records, and failure to do so is grounds for termination from Medicaid. ISMS has requested a legal opinion on whether there is an obligation to obtain patient consent . . . and, if so, who is required to obtain it. Regional officials have forwarded the matter to HEW's general counsel, setting the stage for next month's meeting.

In other Medicaid-related action, the Board voted to again voice strong opposition to the Ill. Dept. of Public Aid's practice of demanding—without legal authority—physician business records during audits. IDPA is trying to legitimize its demand for the records via a new Medicaid rule. ISMS already has challenged the validity of procedures employed by IDPA in filing the proposed rule. The Dept. has not yet filed a final version of the rule.

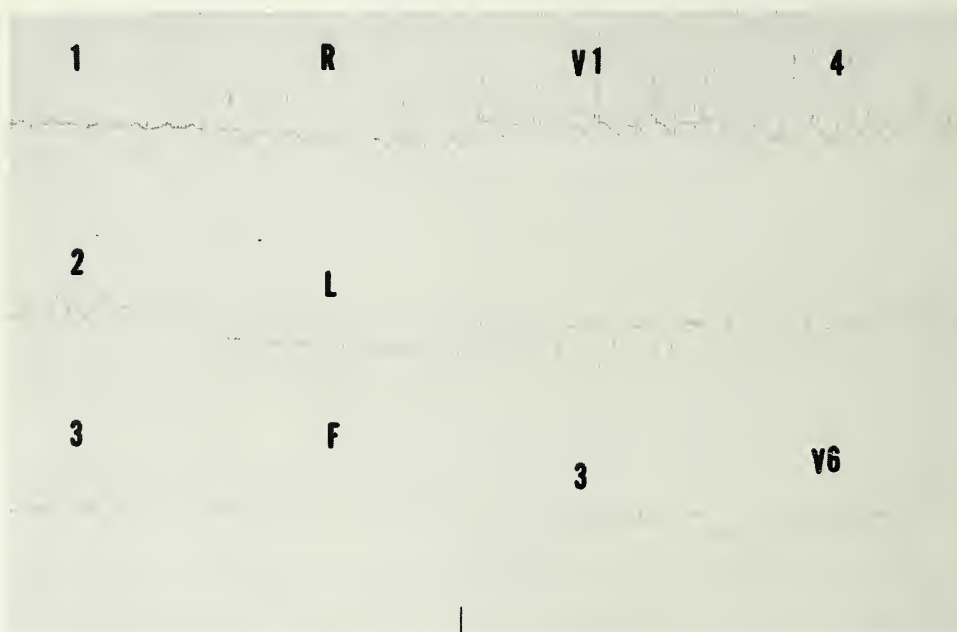
(Continued on page 171)



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

The patient is a 35-year-old man who was referred for a cardiac evaluation. He had had heart surgery at the age of two years but is unclear as to the details. He had done well until one year ago when he developed dyspnea on exertion and was easily fatigued. His personal physician found him cyanotic as well as polycythemic. He required phlebotomy to keep his hemoglobin level below 16.0 gms.%. Physical examination showed cyanosis and peripheral clubbing of the nails. There was a continuous systolic and diastolic murmur in the right infraclavicular area. The heart examination showed a grade 4/6 systolic murmur at the left sternal border, a single second sound, and a 4+ left sternal border lift. The chest X-ray demonstrated cardiomegaly, enlarged pulmonary artery segments, and a right lung field with increased pulmonary blood flow. Cardiac catheterization was recommended. This ECG was taken.



Questions:

1. The ECG shows:

- A. An anterolateral myocardial infarction.
- B. Nonspecific ST-T waves compatible with anterior wall ischemia.
- C. Severe right ventricular hypertrophy.
- D. Right atrial enlargement.
- E. Left axis deviation.

2. The following statement(s) are true:

- A. Cardiac catheterization is required in this patient.

- B. The commonest cardiac malformation characterized by cyanosis and found after infancy is tetralogy of Fallot.
- C. Tetralogy of Fallot refers to a series of four malformations: pulmonic stenosis or atresia, ventricular septal defect, overriding aorta, and right ventricular hypertrophy.
- D. Some patients with tetralogy of Fallot have benefitted from a vascular shunt to increase pulmonary blood flow.
- E. All of the above.

(Continued on page 170)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This 20 month old male entered the hospital because of increasing abdominal mass. IVP (Figure 1) and CT (Figures 2 and 3) were done.

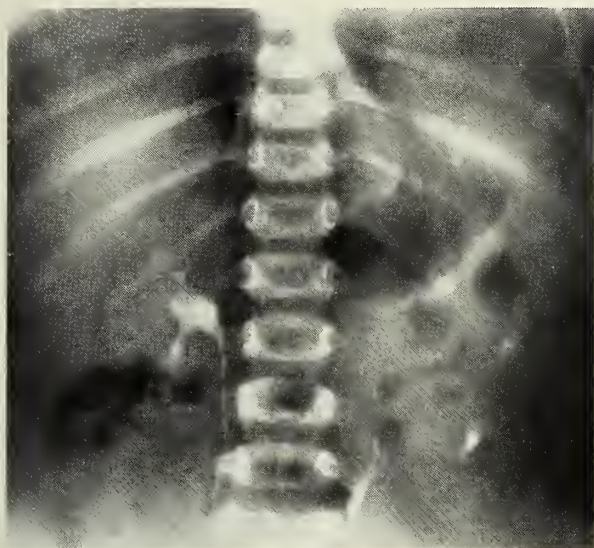


Figure 1

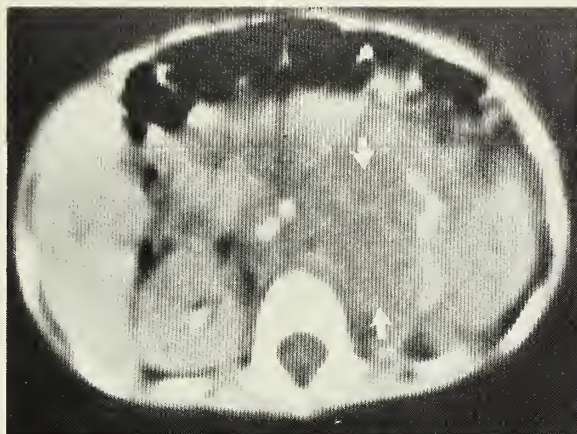


Figure 3

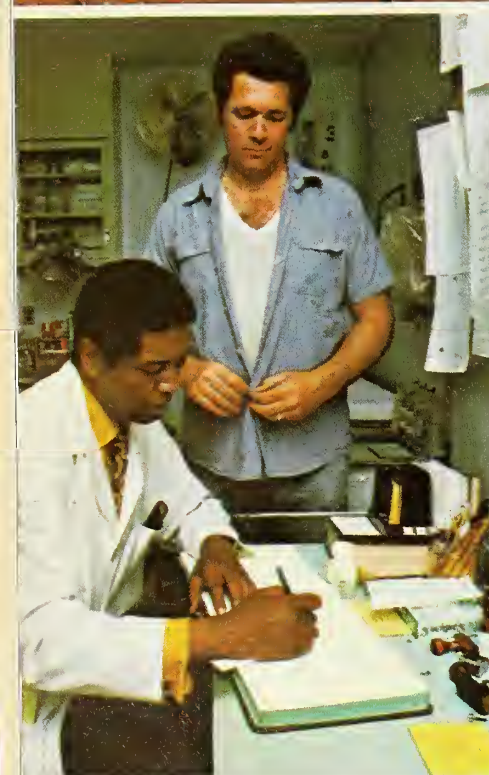


Figure 2

What's your diagnosis?

1. Wilm's tumor
2. Neuroblastoma
3. Lymphoma

(Continued on page 175)



The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.

However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).



Motrin⁴⁰⁰mg TABLETS ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

The confidence that comes from experience—
one more reason to prescribe

Motrin^{400mg} TABLETS

ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)

Bottles of 60

NDC 0009-0733-01

Bottles of 500

NDC 0009-0733-02

Motrin Tablets, 400 mg (orange)

Bottles of 60

NDC 0009-0750-01

Bottles of 500

NDC 0009-0750-02

Unit-dose package of 100

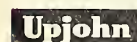
NDC 0009-0750-06

Unit of Use bottles of 120

NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3



The Upjohn Company
Kalamazoo, Michigan 49001

Obituaries

***Glaser, Richard C.**, Aurora, died January 11, 1979, at the age of 60. Dr. Glaser was a 1945 graduate of Chicago Medical School.

***Gorecki, Ferdinand**, Jerseyville, died December 27, 1978, at the age of 66. Dr. Gorecki was a 1941 graduate of the University of Illinois Medical School.

****Halperin, Isadore**, Chicago, died January 5, 1979, at the age of 78. Dr. Halperin was a 1927 graduate of the University of Illinois School of Medicine.

***Kearney, Cletus Timothy**, El Paso, died December 28, 1978, at the age of 70. Dr. Kearney was a 1934 graduate of the University of Illinois School of Medicine.

****Kennedy, Raymond J.**, New Lenox, died January 7, 1979, at the age of 79. Dr. Kennedy was a 1926 graduate of Loyola University Stritch School of Medicine. A physician and surgeon for the Joliet Fire and Police Departments, he also was on the staff of St. Joseph and Silver Cross Hospitals.

***Klabacha, Thaddeus M.**, Chicago, died January 1, 1979, at the age of 65. Dr. Klabacha was a 1941 graduate of the Loyola University Stritch School of Medicine.

***Layman, John Albert**, Moline, died January 11, 1979, at the age of 80. Dr. Layman was a 1933 graduate of the University of Illinois School of Medicine.

***McReynolds, Ralph K.**, Quincy, died January 12, 1979, at the age of 93. Dr. McReynolds was a 1913 graduate of the Rush Medical College. An active member of the Red Cross, he served as a past president and trustee of the Mississippi Valley Medical Society.

Nye, William A., McHenry, died December 29, 1978.

***Potocki, Stanislaw**, Jacksonville, died January 8, 1979, at the age of 65. Dr. Potocki was a 1948 graduate of Bologna University in Italy.

****Steffen, Curt**, Rockford, died January 14, 1979, at the age of 87. Dr. Steffen was a 1918 graduate of the University of Kiel, Germany and is credited with founding the first free cancer clinic for women.

***Taub, Samuel James**, Chicago, died January 11, 1979, at the age of 85.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

LIVING UP TO PRINCIPLES

BY THOMAS E. NESBITT, M.D., PRESIDENT, AMA

This editorial first appeared in the September, 1978 issue of the Hampden Hippocrat, a district medical society publication from Massachusetts.

In my travels, I am frequently asked variations of the same question, "What has the AMA done for me lately?", by disgruntled physicians who often single out our response to government involvement.

So I tell them what the AMA is doing, in the Congress and the courthouse, to prevent arbitrary government intervention, and to preserve the superb, healing quality of American medical education and practice.

Then I turn the tables. I ask the physician, "What have *you* done lately for the AMA, and for American medicine?" I think the question is a fair one, and deserves a fair answer. Because as physicians, we have responsibilities, as well as rights. And the best way to defend the latter is to fulfill the former, particularly our responsibilities in the socio-economic and political dimensions of medical care.

And this fulfillment, in turn, can be best achieved through the support of every physician at every level of this federation of ours, includ-

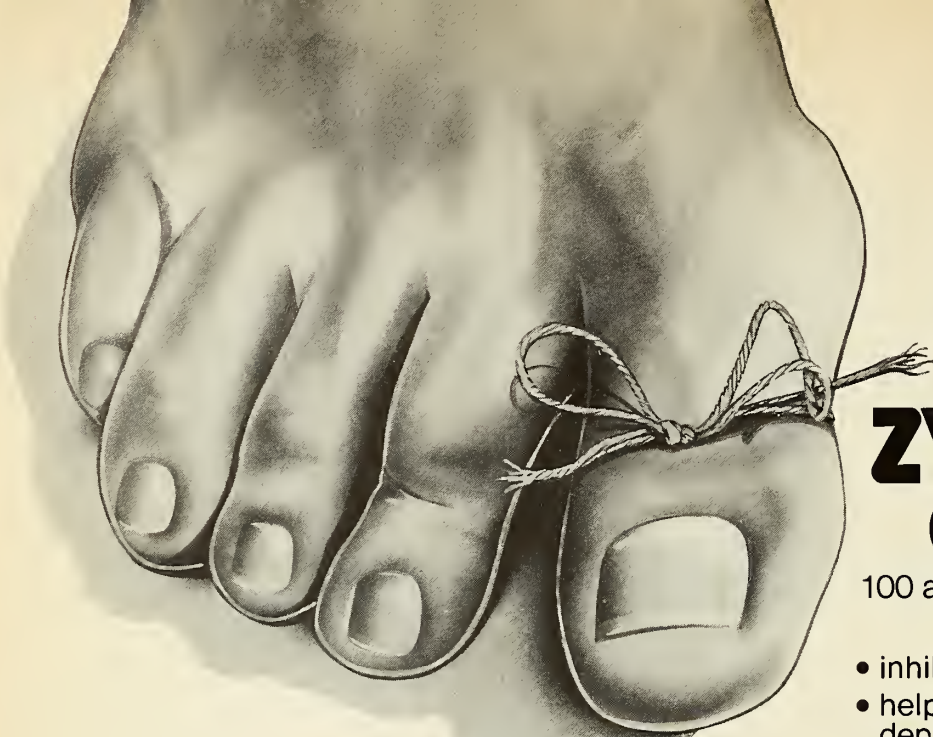
ing the national level. The AMA deserves support.

I believe that each physician who graduates from a U. S. medical school owes a great debt to the AMA, which played (and continues to play) a leading role in making our medical schools the finest in the world.

I believe that each physician privileged to practice in this country owes a great debt to the AMA, which has long guarded (and continues to guard) those opportunities for medical freedom and creativity found nowhere else in the world.

Finally, I believe that each physician who fails to support the AMA is failing to live up to those traditions and principles upon which the past, present, and ultimately the future, of American medicine rest.

Such physicians, the "free riders" of medicine, might heed the words of the late Adlai E. Stevenson, the American attorney and diplomat, who said, ". . . it is often easier to fight for principles than to live up to them." ◀



A reminder

ZYLOPRIM® (allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000, 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

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Project USA: Oklahoma Here I Come

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

For residents or practicing physicians who would like a taste of practice in a "critical shortage area," Project USA places physicians for two weeks or more in shortage areas under the National Health Service Corps Program. Areas of placement are found in many states; a number of openings occur in the Indian Health Service. I have just started a stint at W. W. Hastings Indian Hospital in Tahlequah, Oklahoma, on elective time from my residency program. I would like to share with you the experience of being transplanted from a larger university teaching hospital to a small Public Health Service facility.

Tahlequah became the home of the Cherokee Indians after their tragic force march from the southeastern states along the "Trail of Tears." The Cherokee Indians who survived the march set up a tribal government in Tahlequah after their arrival in 1832. Now a town of some 18,000, Tahlequah still contains the Cherokee National Capitol, built in 1869. Nearby Park Hill contains remnants of the Cherokee Female Seminary (opened 1851) and Cherokee village and museum at Tsa-La-Gi, future Site of the Cherokee National Archives.

W. W. Hastings Indian Hospital, in Tahlequah, is a 40-bed hospital which serves a large out-patient Indian population. Despite limited funds, the hospital does an impressive job of providing modern medical care as well as offering extensive patient education and public health services. The staff includes a general surgeon, two OB/GYN's, internists and family practitioners among the "general medical officers." Several physicians are fulfilling Public Health Service commitments directly following their internships. Sub-specialists are regularly scheduled part-time at the hospital to provide expertise in radiology, orthopedics, ENT, etc. The hospital's one operating room is used for general surgery and GYN surgery on specified days. Emergency surgery can be provided only by calling in surgeon, nurse-anesthetist, and OR personnel from home. The hospital's small laboratory provides a full range of tests and blood banking services on weekdays. Off hours tests require calling a technician from home. For

tests such as CAT scans or ultrasound exams, patients are sent to local hospitals or to Tulsa's teaching hospitals.

I detail the services available because I was struck by the fact that this small 40-bed hospital offers probably 95% of the services available at most large metropolitan teaching hospitals. The smaller staff encourages great versatility. Most lab techs can run every type of test; the OB nurses of necessity must be able to start IV's, interpret monitor tracings and deliver infants who arrive before the physician-on-call arrives on the scene. Most of the physicians are young and recently out of training; they demand the technical sophistication of a teaching hospital.

How do the patients respond? I had been warned to expect resentment of the "great white father" medical center. Instead the patients and the townspeople seem to take pride in "our" hospital. As one part-Cherokee store clerk told me, "In our hospital they'll do well by you or send you to Tulsa if they can't help you. At the City Hospital they just let you lie there if they can't do nothing."

Spending my first Saturday in the Oklahoma hills puttering among the pickup trucks in my VW bug, I wandered through a snow-covered Fort Gibson, an old Indian School, and historical markers of Indian defeats. And I questioned whether big city teaching hospital medicine should comprise all of medical training. For those of you who, like myself, have been reared medically in a University center, may I recommend a stint during a vacation or elective with Project USA? You may find a medicine of a different but viable style; good medicine does not require 1,000 beds and 24-hour CAT scan coverage.

Project U.S.A. provides physicians to critical shortage areas under the National Health Service Corps. Physicians generally serve from two to four weeks and receive reimbursement for travel and housing as well as a \$500.00 stipend weekly. Please direct inquiries to: John Naughton, Project Director, Project U.S.A., c/o American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610 (312) 751-6388. ◀

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Illinois Medical Journal

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Fetal Demise, An Accurate Diagnosis

SANGARAPPILAI ASOKAN, M.D., LUIZ PORTELA, M.D.,
EDUARDO NIJENSOHN, M.D., and ROGER D. PINC, M.D./CHICAGO

An accurate diagnosis of fetal demise was made by using the Time Motion method of ultrasonography. There were no false negative or false positive readings. It is a safe and simple method. The heart beats were detected by changing the echoscope to a Time Motion Mode after localization of the fetal heart or the region of fetal heart by B-Scans. Failure to detect the fetal heart beat was indicative of fetal demise.

Determination of fetal demise is an important clinical diagnosis. The number of radiological signs already described in the literature attest to the fallibility of this method.¹ Further, there is also the possibility of associated radiation hazards.

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LUIZ PORTELA, M.D., is a board certified diagnostic radiologist currently pursuing a fellowship in neuroradiology at Rush-Presbyterian-St. Luke's Medical Center, where he completed his residency in diagnostic radiology in June, 1978.

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ROGER D. PINC, M.D., is former chairman of the Department of Radiology at both Edgewater and Cook County Hospitals in Chicago. Currently in private practice, Dr. Pinc is a diplomate of the American Board of Radiology and has served as an instructor at the University of Chicago Pritzker School of Medicine and director of radiologic research at the Hektoen Institute for Medical Research.

More recently, ultrasonographic signs of fetal demise were described, some of which are counterparts of the radiological signs.^{2,3} Since the heart beats are a "sine qua non" of fetal life, lack of fetal heart beats would be indicative of fetal demise. It was the lack of a sensitive method that hindered this logical approach. With a little experience, the Time Motion method can be utilized in the diagnosis of fetal demise with a great degree of success.

Material And Methods

Fifty-four patients were referred in a period of about two years (January, 1975 to February, 1977) to rule out fetal demise. The patients were more than 20 weeks of gestational age as calculated by the LMP.

As part of their clinical workup, eleven patients also had radiographic examinations. This number declined as the diagnostic accuracy of the ultrasonographic method was recognized.

The echographic routine in these cases consisted of a series of B-Scans in the longitudinal and transverse directions, including the entire pregnant uterus. After localization of the fetal heart or the region of fetal heart, (Fig. 1A) the transducer is held on the maternal abdomen over the position of the fetal heart. The machine is

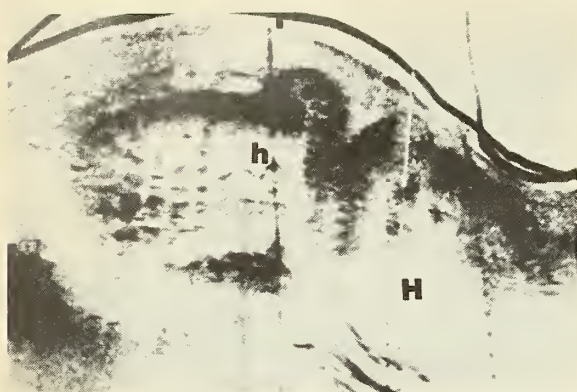


Figure 1A

The transducer (T) is placed over the position of the fetal heart (h) on the maternal abdomen. The wavy line within the heart represents the interventricular septum. H—fetal head.

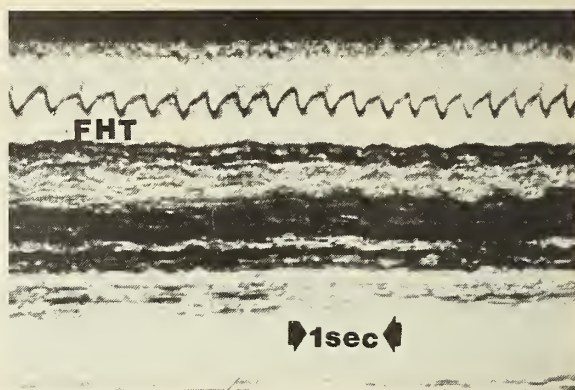


Figure 1B

The fetal heart tones (FHT) after conversion to the time-motion mode.

converted to a Time Motion Mode and the fetal heart beats are recognized by fractional movements of the transducer. (Fig. 1B) All moving structures are presented in a wave form while stationary structures are represented as straight lines.⁴ Failure to detect the heart beats is indicative of fetal demise. (Fig. 2A, 2B)

Results

In 27 patients, the fetal heart beats were recorded by the Time Motion Mode, including two in which a previous attempt at auscultation with a Doptone had been negative. Most of these patients gave birth to live babies, others had continuing pregnancies. In 27 patients, the fetal heart beats could not be recorded by the Time Motion Mode;

all these patients delivered dead fetuses within a period of two days to three weeks. Eleven of these patients had abdominal radiographs with only six showing signs of fetal demise. (Table 1) The B-Scan signs of fetal demise were seen in 13 out of 27 cases. (Table 2)

Discussion

The classical radiographic signs of fetal demise and their echographic counterparts proved to be less accurate than the simple and safe technique of recording the fetal heart beats with the Time Motion Mode, which is available with most B-Scan equipment.

Though, there were no false positive or negative diagnoses, one has to be cautioned that it requires

Figure 2A-2B: Fetal Demise

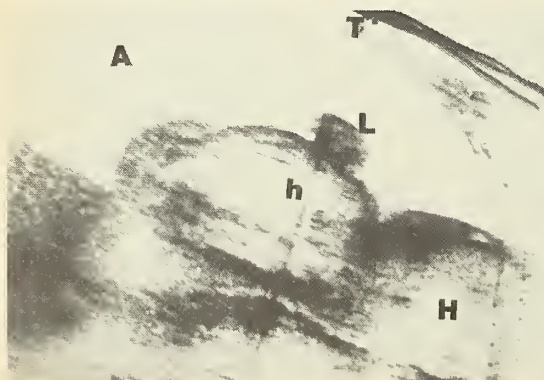


Figure 2A

The transducer (T) is placed over the position of the fetal heart (h) on the maternal abdomen. H—fetal head, L—limbs, A—amniotic fluid.

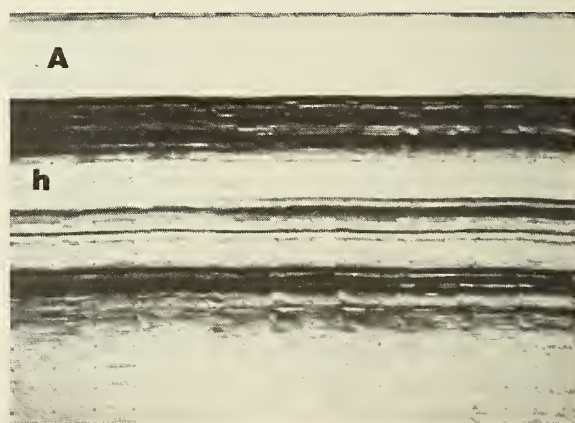


Figure 2B

The fetal heart tones were not detected in the region of the fetal heart (h) after conversion to the time-motion mode. A—amniotic fluid.

Table 1

Radiographic Findings	Total Number of Patients	11
No Evidence of Demise	5	
Abnormal Position	4	
Spalding's Sign	4	
Halo Sign	1	
Fetal Gas	1	
Diagnostic Accuracy	6/11	54%

some experience before the examiner can be convinced that the failure to detect the fetal heart beats is not due to faulty technique. This experience is easily acquired by detecting the heart beats of fetuses in all routine obstetric cases.

Though no comparative study was done between the Doptone and the Time Motion Mode of examination, two cases where the fetal heart beats could not be detected by the Doptone were detected by the Time Motion Mode. One was a case of marked hydramnios which is known to be a cause of Doptone inaccuracy. The other case proved to have a congenital malformation of the heart and died a few days after birth. The reason for the Doptone failure in this case is unclear. Though the Doptone is a simpler and cheaper instrument, it also requires experience before a diagnosis of fetal demise can be made with confidence.

With the availability of these accurate methods of diagnosis, radiographic examination for fetal

Table 2

Echographic Findings	Total Number of Patients	27
No Evidence of Demise	13	
Fluffy Thorax	6	
Deformed Thorax	5	
Double Lines in the Head	8	
Small Head, Overlapping Lines	1	
Diagnostic Accuracy	14/27	52%

demise should probably be discontinued, not only for its lower diagnostic yield, but for the possible radiation hazards to a live fetus. B-Scan findings of fetal demise, though helpful, should not be a substitute for the Time Motion study. Real Time Scanning is also a very accurate way to diagnose fetal demise, but may not be available in every ultrasound laboratory. ◀

References

1. Doonan, C. D.: "Radiographic Diagnosis of Fetal Death," *RADIOLOGICAL CLINICS OF NORTH AMERICA*, Vol. XII, No. 1 Page 29-35, April, 1974.
2. Gottesfield, K.: "Ultrasonic Diagnosis of Intrauterine Fetal Death," *Am. Journ. Obgyn.* 108:623, 1970.
3. Sanders, R. C., Conrad, M. R.: "Sonography in Obstetrics," *RADIOLOGICAL CLINICS OF NORTH AMERICA*, Vol. XIII, No. 3, Page 435-455, Dec., 1975.
4. Asokan, S., Premasagar, D.: "Detection of Fetal Heart Beats Using the T.M. Mode," *ULTRASOUND IN MEDICINE*, Vol. 2: 207-212, 1976.

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Management of Drug Overdose

Rapid Whole-Gut Evacuation

By ANTONIO BOBA, M.D./BAKERSFIELD, CA.

Rapid evacuation of the whole gut in patients who have ingested a drug overdose and who are brought to the physician's attention while the ingested agent may be presumed within the lumen of the bowels can favorably alter clinical course and outcome. A method for rapid evacuation of the whole gut which has been found effective for the purpose of bowel preparation prior to major resections has been employed in two patients who had ingested presumed overdoses of a drug mix. Prompt evacuation followed by a very mild course were noted in both instances. Results are reported in the belief that this ancillary measure has a proper place in the management of early drug overdose.

This brief report shall attempt to describe a simple and reliable maneuver which allows for very rapid mechanical evacuation of the whole gut. Such a procedure is desirable when the patient is seen soon after drug ingestion. It is appropriate when the ingested agent may be presumed to have left the stomach but still be within the lumen of the small bowel (thus not yet absorbed). Clearly, the rapid evacuation of any unabsorbed material should alter substantially the clinical course and eventual outcome.

The dynamics of the procedure are best perceived by recalling that the content of the gastrointestinal tract is "outside the body." Absorption/elimination processes are largely controlled by absolute and relative pressure gradients. If

the tract is filled with a large volume of isotonic/isoionic solution effective purgation and removal by entrainment of particulate matter can be accomplished as this bulk is eliminated without significant net gain or loss from the body to the gastrointestinal tract.

This objective is accomplished by inserting a small nasogastric tube, propping the patient in a sitting or semi-sitting position on a commode and administering lactated Ringer's solution through the tube at the rate of approximately 300 ml/min to a total of 4.0 to 6.0 liters. The continued presence and quality of bowel sounds throughout the procedure should be monitored. Under ordinary conditions, emptying of the bowels begins in 8 to 10 minutes and after 20 to 25 minutes only a clear watery solution is eliminated.

The basic dynamics of the process have been explored at length¹ and the procedure has been successfully used for bowel preparation prior to major resections in non-obstructed patients.² It has also been found effective for eviction of such heavy objects as lead pellets.³

This procedure, whose proper label should be "whole gut purgation," was employed in one patient who came to the hospital within 90 minutes of ingesting a combination of diazepam/spironolactone/hydrochlorothiazide. It was also



ANTONIO BOBA, M.D., is chairman of the department of anesthesia for Kern Medical Center in Bakersfield, CA, and a clinical professor of anesthesiology at U.C.L.A. At this writing, Doctor Boba was director of anesthesia at the Southern Illinois Clinic, Ltd., and the director of the intensive care unit for Jefferson Memorial Hospital in Mount Vernon.

Table 1
Values For Venous Blood Electrolytes (mEq/liter)
Collected After Completion of Bowel Evacuation

	Na	K	Cl	CO2 (*)	BUN
Patient A	136	3.8	106	24	16
Patient B	141	3.9	105	23	14

Patient A (Female, age 42) ingested diazepam/spironolactone/hydrochlorothiazide and received 4000 ml of lactated Ringer's solution via the nasogastric tube.

Patient B (Female, age 24) ingested diphenylhydantoin/propoxyphene/codeine/acetaminophen and received 6000 ml of lactated Ringer's solution via the nasogastric tube.

(*) Carbon dioxide combining power in mEq/liter

employed in a second patient who had ingested a combination of diphenylhydantoin/propoxyphene/codeine/acetaminophen also within 90 minutes of coming to the hospital. Effective whole gut purgation, to include the elimination of all particulate matters, was promptly accomplished in both patients without any detectable effects on pulse rate, blood pressure, respiratory

rate and the electrocardiogram and without demonstrable effects on plasma electrolytes concentration (Table 1). Both patients' levels of consciousness, which at the time of the procedure could have been described as "slightly obtunded," did not exhibit further deterioration and both patients were awake, alert and well oriented within four hours of admission to the Intensive Care Unit.

Summary

A method for the purpose of rapid whole gut evacuation for bowel preparation prior to bowel resection has been also shown to be of ancillary value in the management of acute drug overdose.

References

1. Love, A. H. G., Mitchell, T. G. and Phillips, R. A.: "Water and Sodium Absorption in the Human Intestine," *Journal of Physiology*, 195:133, 1968.
2. Hewitt, J. and Rigby, J.: "Whole-gut Irrigation in Preparation for Large Bowel Surgery," *Lancet (II)*: 337, 1973.
3. Woo, P., Hatfield, A., Green, J. R. and Hamilton, S. M.: "Whole gut Perfusion for Therapeutic Purgation," *British Medical Journal (I)*, 433, 1976.

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IMMUNIZATION STATUS OF ILLINOIS CHILDREN IN KINDERGARTEN

This table is reprinted at the request of Paul Q. Peterson, M.D., director of the Illinois Department of Public Health. Dr. Peterson has asked for assistance in a campaign to achieve adequate immunization for 90% of Illinois children entering kindergarten.

As the table demonstrates, Illinois is far beneath that "herd protection" ratio in child immunization. Data from a 1977 survey conducted by IDPH and the Illinois Office of Education covering 160,000 children, are presented both in terms of the percent immunized and the estimated number still susceptible.

It is clear that the present rate of immunization is insufficient to prevent an epidemic of childhood disease. IDPH has called upon Illinois physicians to work for greater participation in private practice and through community action.

(based on 1977 survey of 160,000 persons)

COUNTY	POLIO		DTP		MEASLES		RUBELLA		MUMPS	
	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized
Adams	515	56	647	45	163	86	166	86	389	67
Alexander	108	41	154	15	21	88	32	82	83	54
Bond	113	46	161	23	59	72	68	67	90	57
Boone	144	69	283	38	72	84	84	82	94	80
Brown	46	47	61	30	11	87	17	80	21	76
Bureau	259	43	353	23	87	81	137	70	145	68
Calhoun	32	67	40	59	15	85	17	83	41	58
Carroll	71	71	218	10	58	76	66	73	86	64
Cass	47	77	54	74	33	84	30	85	31	85
Champaign	1,018	48	1,479	24	521	73	573	71	716	63
Christian	202	66	356	40	118	80	131	78	167	72
Clark	47	77	170	15	29	86	31	85	95	53
Clay	94	58	157	30	36	84	43	81	57	74
Clinton	247	48	357	25	76	84	110	77	167	65
Coles	402	38	547	16	137	79	138	79	235	64
Cook	38,130	43	48,730	27	24,917	63	28,203	58	34,938	48
Crawford	152	53	288	11	92	71	102	68	102	68
Cumberland	100	37	148	6	56	65	57	64	74	53
DeKalb	305	69	568	43	168	83	180	82	229	77
DeWitt	179	34	203	25	30	89	35	87	39	86
Douglas	196	40	209	35	49	85	53	84	86	73
DuPage	2,258	74	4,584	48	1,396	84	1,643	81	1,968	78
Edgar	182	53	255	34	39	90	78	80	147	62
Edwards	46	55	68	34	38	63	41	60	48	53
Effingham	173	66	218	57	11	98	11	98	14	97
Fayette	215	43	310	18	105	72	129	66	139	63
Ford	103	51	109	48	60	71	68	67	78	63
Franklin	177	71	446	27	126	79	169	72	223	64
Fulton	513	28	581	19	133	81	179	75	167	77
Gallatin	63	11	71	0	28	61	34	52	36	49
Greene	85	21	80	26	9	92	10	91	13	88
Grundy	313	52	406	38	80	88	94	86	175	73
Hamilton	9	92	19	82	5	95	5	95	31	71
Hancock	238	29	277	18	65	81	92	73	148	56
Hardin	17	47	28	13	4	88	4	88	12	63
Henderson	40	62	64	38	34	67	35	66	48	54
Henry	251	72	562	37	148	84	160	82	224	75
Iroquois	272	48	469	11	61	88	121	77	123	77
Jackson	283	57	402	39	148	77	178	73	216	67
Jasper	84	52	140	20	37	79	40	77	42	76
Jefferson	191	66	304	46	166	71	329	42	292	48
Jersey	220	36	277	20	72	79	98	72	122	65
Jodavie	219	46	340	16	44	89	46	89	58	86
Johnson	71	37	96	15	34	70	43	62	61	46
Kane	1,661	72	2,782	53	1,031	83	1,181	80	1,494	75
Kankakee	379	62	636	35	99	90	125	87	248	75
Kendall	105	83	400	36	83	87	107	83	123	80
Knox	573	29	713	12	364	55	381	53	392	51
Lake	2,482	64	3,905	44	1,414	80	1,830	74	2,124	70
LaSalle	825	51	1,198	29	314	81	472	72	610	64
Lawrence	46	80	184	19	10	96	9	96	32	86
Lee	297	42	434	15	103	80	113	78	185	64
Livingston	180	69	408	30	62	89	79	86	154	74
Logan	235	39	334	13	47	88	62	84	88	77
McDonough	161	66	298	37	52	89	71	85	107	77
McHenry	980	58	1,315	43	430	81	481	79	546	76
McLean	627	65	1,146	36	256	86	301	83	450	75
Macon	870	58	1,277	39	196	91	293	86	644	69
Macoupin	321	59	597	23	91	88	138	82	213	73
Madison	1,255	69	2,184	46	684	83	1,062	74	1,541	62
Marion	213	63	387	32	106	81	134	77	186	67
Marshall	148	31	169	21	27	87	38	82	49	77
Mason	241	35	338	9	121	68	146	61	153	59
Massac	15	61	25	34	12	68	13	66	14	63
Menard	91	50	89	51	59	68	56	69	60	67

COUNTY	POLIO		DTP		MEASLES		RUBELLA		MUMPS	
	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized	Number Susceptible	Percent Immunized
Adams	115	65	224	32	67	80	80	76	105	68
Alton	82	69	174	34	24	91	36	86	70	73
Armstrong	183	60	300	34	140	69	152	67	163	64
Aurora	105	81	153	73	78	86	144	74	207	63
Barr	70	37	65	41	25	77	26	77	26	77
Bell	193	73	456	36	91	87	103	86	173	76
Berk	1,901	42	2,389	28	693	79	847	75	931	72
Bloomington	123	61	215	32	45	86	92	71	79	75
Bond	145	47	196	28	48	82	56	79	101	63
Bureau	48	23	52	16	18	71	18	71	31	50
Calhoun	31	49	48	21	21	66	21	66	32	48
Carroll	75	21	95	0	5	95	4	96	15	84
Cass	55	41	57	39	7	92	13	86	17	82
Champaign	315	43	440	20	140	75	177	68	213	61
Clark	48	82	78	70	7	97	17	94	58	78
Clatsop	888	62	1,509	36	756	68	773	67	1,038	56
Clatsop	2,027	52	2,804	34	1,218	71	1,503	65	1,648	61
Clatsop	235	24	253	19	122	61	133	57	154	50
Clatsop	881	63	1,511	37	512	79	559	77	709	70
Clatsop	35	65	93	8	20	80	20	80	24	76
Clatsop	44	53	50	46	15	84	21	77	34	63
Clatsop	267	20	276	18	100	70	106	68	160	52
Clatsop	19	84	55	55	10	92	11	91	17	86
Clatsop	103	86	469	38	40	95	43	94	73	90
Clatsop	435	78	525	74	258	87	326	84	417	79
Clatsop	146	45	197	26	46	83	52	81	90	66
Clatsop	1,004	33	1,371	8	538	64	597	60	969	35
Clatsop	98	55	208	4	5	98	15	93	62	71
Clatsop	242	40	288	29	55	86	78	81	109	73
Clatsop	66	66	173	11	47	76	58	70	69	65
Clatsop	116	49	159	31	76	67	87	62	105	54
Clatsop	132	43	123	47	49	79	64	72	114	51
Clatsop	403	63	663	40	106	90	123	89	266	76
Clatsop	1,414	74	2,328	57	875	84	1,050	81	1,501	72
Clatsop	524	42	684	24	268	70	349	61	383	58
Clatsop	1,738	58	3,068	26	1,002	76	1,164	72	1,489	64
Clatsop	399	24	424	19	178	66	242	54	259	51

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their

patients of this service.

April 23	Park District Bldg.	Hickory Hills
May 8	Daley Center	Chicago
May 13	Seventh Day Adventist Church	Hinsdale
May 14	Christ Hospital	Oak Lawn
June 5	Daley Center	Chicago
July 8	Seventh Day Adventist Church	Hinsdale
August 6	YWCA	Rockford
September 9	Seventh Day Adventist Church	Hinsdale
September 10	Christ Hospital	Oak Lawn
September 17	St. Therese Hospital	Waukegan
October 8	Lake Forest Hospital	Lake Forest
November 5	YWCA	Rockford
November 5	Christ Hospital	Oak Lawn
November 11	Seventh Day Adventist Church	Hinsdale



Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Immunology of Atopy

BY KENNETH P. MATHEWS, M.D./MICHIGAN

Efforts to elucidate mechanisms of atopic diseases date back to Blackley's observation in 1873 that applying an offending allergen to the abraded skin of atopic persons results in the rapid development of a wheal-and-flare reaction at the test site. Decades later, in 1921, Prausnitz and Kustner found that this cutaneous reactivity could be passively transferred by serum of an allergic individual to the skin of a normal recipient. There followed years of unsuccessful efforts to identify in serum the mysterious "atopic reagins" which presumably might play a pathogenetic role in atopic diseases. These conditions, which include allergic rhinitis, allergic asthma, atopic dermatitis, and some forms of urticaria, were so named by Coca and Cooke in 1923 to denote naturally occurring human diseases associated with wheal-and-erythema skin reactions that tended to occur in certain families. Major progress in this area has occurred primarily in the last 15 years largely through (1) the discovery of IgE,¹ and (2) systematic *in vitro* studies of mediator release by allergens from basophils or lung mast cells.²

From the viewpoint of the clinician dealing with atopic patients, one's immediate concern is the mechanisms whereby allergic symptoms are triggered on re-exposure to an allergen. Although it is possible that some atopic hypersensitivity reactions are mediated by certain subclasses of IgG molecules, it is likely that the large majority

are initiated by the interaction of inhaled, ingested or injected allergens with IgE molecules which are attached to mast cells or basophils via the Fc portion of these molecules. As compared with IgG, IgE has a higher molecular weight (190,000), higher sedimentation coefficient (8.25), more attached carbohydrate (11-12%), and longer H chains containing 6 disulfide bonds.¹ There are 2 specific epsilon chain determinants but no known subclasses of IgE. The cause for its important biologic property of sticking avidly (K_a about 10^9) to basophils or mast cell membranes is unknown. Currently there is considerable interest in characterizing the cell membrane receptors for IgE. There is great variability in the number per cell, ranging from 4,000 to 500,000 per human basophil.³ Generally, more of these receptor sites are occupied by IgE molecules in atopic subjects than in normals, but the number of occupied receptor sites can be increased by incubating the cell with IgE.

Mediator Release

Considerable evidence indicates that 2 or more molecules of membrane-bound IgE must react with one molecule of polyvalent allergen in order to produce mediator release; immunologically univalent haptens which fail to produce this "bridging" effect are inactive. Release of mediators from mast cells or basophils also can be achieved by reacting them with anti-IgE antibodies or anti-receptor antibodies.⁴ In this process of immunologic mediator release it can be shown that the surface IgE molecules may become rearranged in patches or caps on basophils in a manner analogous to surface IgG patterns on lymphocytes after reactions with anti-Ig antiserum. These observations indicate the mobility of IgE and its receptors in the cell membrane

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lipid. However, quantitative aspects of the process suggest that patching and capping are not integral aspects of mediator release.

Whereas these events at the cell membrane have been quite well characterized, it is less clear how the message to release their content of various mediators is transmitted from the cell membrane to the granules inside the cell; no physical continuity between the cell membrane and granule membrane has been demonstrated in basophils or mast cells. It should be emphasized that the release of mediators by these cells does not represent cell injury with subsequent leakage of these substances from dying cells. Instead, the active secretion of mediators is to be viewed as an important physiologic function of these cells. The process may be divided into 2 stages: activation and secretion. (Fig. 1) The detailed steps involved may differ slightly between mast cells and blood basophils. In the former case, for example, the initial step may involve activation of a serine esterase, whereas evidence for this is lacking in the human basophil. In both instances, however, the activation phase appears to be modulated importantly by intracellular levels of cAMP; increases in cAMP decrease mediator release. Accordingly, mediator release is inhibited by agents such as β_2 adrenergic agonists, prostaglandins of the E series and cholera enterotoxin, which stimulate adenylate cyclase; phosphodiesterase inhibitors have a similar effect. Conversely, alpha adrenergic agents enhance mediator release, probably through stimulation of membrane ATPases with subsequent decreases in cAMP. Mediator release by allergens also is associated with falling levels of cAMP. On the other hand, increased cGMP favors mediator secretion from mast cells.⁵ Thus, acetylcholine and $\text{PGF}_{2\alpha}$, which are guanylate cyclase agonists, enhance mediator release from these cells. It should be emphasized that several of these pharmacologic agents also may influence allergic reactions through direct effects on target tissues in addition to their role in modulating mediator release.

The secretory phase of mediator release requires energy from glycolysis and is inhibited by 2-deoxyglucose. Calcium ions also play an important role, and indeed calcium ionophores in themselves are capable of producing mediator release! The release process involves migration of the cell granules to the surface with fusion of the granule and cell membranes.⁶ Microtubules may somehow be involved in this process, since agents, such as colchicine, which inhibit microtubule aggregation, also inhibit mediator release, whereas

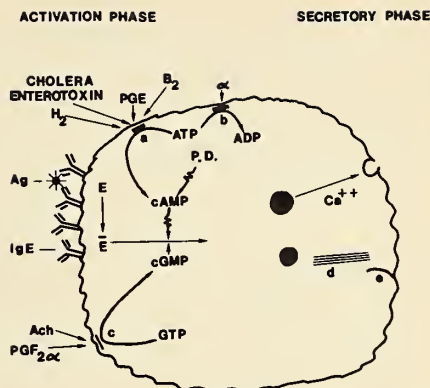


Figure 1

Schematic diagram of mediator release from mast cells or basophils (see Text). a-adenylate cyclase; b-ATPase; c-guanylate cyclase; d-microtubules; e-microfilaments; β_2 - β_2 adrenergic agonists; α - α adrenergic agonists; P.D.-phosphodiesterase; H_2 -histamine stimulating an H_2 receptor.

deuterium oxide has the opposite effect both on mediator release and microtubule aggregation. It also should be noted that cAMP inhibits microtubule aggregation, thus providing a possible link with the first phase of mediator release.⁷ The additional possible involvement of the microfilament system is suggested by the fact that cytochalasin B, a microfilament inhibitor, also influences mediator release.

Mediators of Atopic Diseases

The major mediators of atopic and anaphylactic reactions are listed in Table 1. Once released, histamine may produce locally increased vascular permeability and smooth muscle contraction, effects which can account for many features of atopic diseases; or histamine can initiate vagal reflexes which may be important in asthma. Slow reacting substance of anaphylaxis, SRS-A, is formed and released in significant quantities by human mast cells following exposure to allergens. It has a potent effect in producing sustained contraction of human bronchiolar smooth muscle. Difficulty in characterizing SRS-A has delayed progress in work with this mediator, but recent developments have indicated it is a low molecular weight substance containing one sulfur atom which may be derived in part from arachadonic acid.⁸ Eosinophil chemotactic factor of anaphylaxis (ECF-A) has the function implied by its name. It is a tetrapeptide having the amino

Table 1
Mediators of atopic diseases and/or anaphylaxis

Primary	Secondary	Newly described
Histamine	Kinins	Superoxide
Slow-reacting substance of anaphylaxis (SRS-A)	Prostaglandins	Superoxide dismutase
		Neutrophil chemotactic factor (NCF)
Eosinophil chemotactic factor of anaphylaxis (ECF-A)	Possible*	
Basophil Kallikrein of anaphylaxis (BK-A)	Heparin Serotonin	
Platelet activating factor(s) (PAF)	Chymase	

*Definitely released in other species but importance in human atopic disease is not established.

acid sequence of either ala-gly-ser-glu or val-gly-ser-glu.⁹ Basophil kallikrein of anaphylaxis (BK-A) is an arginine esterase capable of splitting kinins from kininogen. This is one mechanism whereby kinins might secondarily be involved in the pathogenesis of atopic conditions; alternatively, if histamine permits kininogen to escape from the intravascular compartment, kinins may be cleaved in the connective tissue. Platelet activating factor (PAF) has been studied especially in rabbits where some of the mediators are stored in the platelets rather than basophils, being released under the influence of PAF; its importance in man is not well delineated at present.

In addition to these generally accepted mediators, current investigations in animals and man suggest that this list is likely to expand rapidly in the very near future to include a neutrophil chemotactic factor,¹⁰ superoxide, superoxide dismutase, and chymase. The release of heparin and serotonin have been long known in other species, but serotonin is not present in human basophils, and the importance of heparin release in humans is uncertain. As mentioned above, prostaglandins modulate mediator secretion by mast cells and may have other important roles in atopic diseases, especially relating to their capacity to constrict or relax smooth muscle. It also should be noted that in addition to antigen or anti-IgE induced secretion of these mediators, mast cells and/or basophils can be stimulated to secrete these substances by a variety of other agonists including anaphylatoxins (C5a and C3a), kinins, calcium ionophores, concanavalin A and other

lectins, anti-light chain sera, radiographic contrast media, compound 48/80, and a large number of histamine liberator drugs (including morphine, codeine, meperidine, d-tubocurarine, polymyxin antibiotics and thiamin).

Rather recently attention has been directed toward mechanisms which limit or "turn off" allergic inflammation of the atopic type. One such process is a negative feedback by histamine. Through stimulation of H₂ receptors on basophils and mast cells, histamine can stimulate adenylate cyclase, increase cAMP and inhibit mediator release. The eosinophil plays a protective role in 4 ways: (1) through its content of histaminase, which inactivates histamine; (2) through its arylsulfatase B, which inactivates SRS-A; (3) through its prostaglandin content, which has a net effect of inhibiting histamine release; and (4) through its phospholipase D, which inactivates PAF.

IgE Immune Responses

The foregoing discussion dealt with processes of major concern to clinicians dealing with atopic patients who are suffering from the effects of exposure to allergens to which they are sensitive. However, it ignored the more basic question of how the patients developed this form of sensitivity in the first place. In general, the immunological responses of atopic persons to allergens follows the same principles applicable to all types of immune responses. While consideration of this broad subject is beyond the scope of this discussion, recent findings specifically relating to IgE responses to antigens merit comment (Fig. 2).

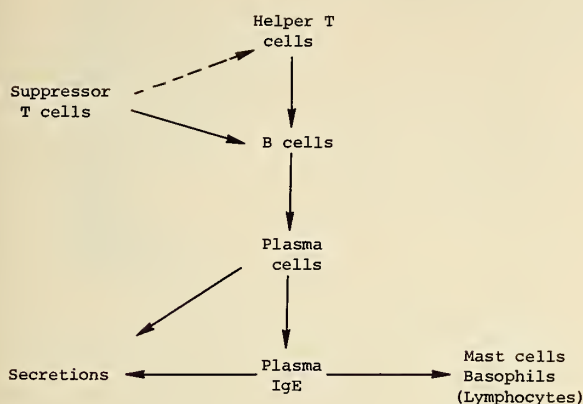


Figure 2
Formation and distribution of IgE.

Studies of IgE responses in experimental animals indicate that low dose carrier immunization favors IgE formation,¹¹ while IgG formation is favored by larger doses of carrier, its incorporation into complete Freund's adjuvant, or employing denatured carrier. Results of both *in vitro* and *in vivo* experiments have suggested that there are separate helper T cell populations for IgE and IgG antibody formation, though there is some controversy about this matter. It also is noteworthy that a T-independent antigen, DNP-Ficoll, can stimulate IgE antibody formation in suitably primed animals.

There is great current interest in the role of suppressor T cells in IgE antibody formation. Attention was directed to this subject by Tada's series of investigations¹² which showed that a variety of experimental manipulations which ordinarily would be expected to be immunosuppressive actually *increased* IgE antibody formation in rats and other experimental animals. This included adult thymectomy, X-irradiation, immunosuppressive drugs and antithymocyte serum. Similarly, others have shown that X-irradiation and cyclophosphamide enhance IgE, but not IgG, formation in adoptive transfer experiments. Also, non-responder mice (to certain antigens) can be converted to responder animals by these means.¹³ The explanation offered for these and other surprising findings is that suppressor T cells for IgE formation are removed by these experimental maneuvers. This is supported by the observation that injecting T cells abrogates the enhanced IgE antibody formation. Further, an antigen-specific soluble suppressor factor can be obtained from disrupted T cells. There also are non-specific suppressor substances derived from T cells, and sev-

eral investigators currently are studying the identity of these suppressor materials. Of particular relevance to this discussion is the recently described histamine-induced suppressor factor.¹⁴ This substance is produced by lymphocytes after stimulation of H₂ receptors and is capable of suppressing MIF production and lymphocyte transformation. Laboratory researchers also are evaluating means of selectively increasing suppressor T cells for IgE antibody formation and some success has been reported by haptens coupled to mycobacteria.¹⁵

Needless to say, it is tempting to extend these experimental findings to human diseases characterized by high levels of IgE antibodies. There is a considerable body of data documenting some impairment of cell-mediated immunity in groups of subjects with atopic dermatitis as manifested by decreased sensitivity to Rhus oleoresin, decreased ability to be sensitized with DNCB, decreased responsiveness to a battery of antigens from infectious agents and anergic responses to trichophyton during active infection.¹⁶ There are conflicting reports about reduced numbers of circulating T cells in patients with atopic dermatitis or bronchial asthma.¹⁷ However, the interpretation of this information is unclear at present, since impaired cellular immunity in some conditions is associated with *increased* suppressor cell activity. Recent *in vitro* studies have shown that normal lymphocytes inhibit the pronounced IgE synthesis by atopic patients' lymphocytes but not IgG or IgM synthesis or proliferative responses.

Less attention has been directed toward B cells involved in IgE formation. It is known that they are more resistant to X-irradiation than IgG-forming B cells, but there are conflicting reports as to whether they have a separate lineage from cells which switch over from IgM to IgG and IgA formation. The plasma cells derived from IgE B cells (Fig. 2) are located most prominently in the tonsils, bronchi, and mucosa of the gastrointestinal tract. Compared with other plasma cells, they are only sparsely found in spleen, bone marrow or peripheral lymph nodes. This distribution of IgE-forming plasma cells suggests local antibody formation near the sites of allergen absorption. The high level of IgE antibodies in nasal polyp fluid is in accord with this assumption.

IgE is present in much lower concentration in the circulating plasma than the other immunoglobulins, the geometric mean value for adults being in the range of 100 ng/ml. It also has the most rapid turnover with a T/2 in plasma of about 2.4 days. It can be detected in nasal wash-

ings, primarily in atopic subjects. When present, it may be in higher ratio to albumin than in serum, but there is no secretory piece. Available data suggest some local production and secretion but relatively to a lesser extent than IgA.¹⁸ IgE is absent from parotid fluid, and more recent data indicate it is essentially absent from human colostrum and milk. In addition to some IgE being taken up on the surface of mast cells and basophils, as described above, recent data indicate that about 4% of normal peripheral blood lymphocytes have receptors for IgE.¹⁹

The foregoing description of IgE synthesis and distribution still does not account for why some people develop atopic diseases and others do not. The explanation(s) for this must take into account the tendency for these diseases to cluster in certain families and may well involve multiple genetically determined factors. Among several possibilities, current investigations are focusing particularly on 3 areas: (1) as previously shown in experimental animals, limited data indicate the occurrence in man of immune response genes which determine the capacity to respond to specific antigenic determinants with IgE antibody formation; (2) as discussed above, a deficiency of suppressor T cells for IgE formation could be a critical factor; this might or might not be related to (1) above; and (3) abnormal absorption of allergens across mucous membranes, for a variety of possible reasons, also might be critical, though there are conflicting data in this area.

The clinical implications of this burgeoning information regarding the immunology of atopy are obvious. In the already sensitized patient, current knowledge suggests many therapeutic approaches for inhibiting mediator release or inhibiting their effects on target tissues. At a more basic level, developing information may possibly lead to clinical means of stimulating suppressor T cells for IgE antibody formation, immunization procedures which assure IgG and not IgE antibody production, the development of anti-idiotypic antibodies,²⁰ or immunologic tolerance for IgE antibody formation, the latter possibly through the use of conjugates with polyethylene glycol or copolymers of D-glutamic acid and D-lysine. ◀

References

1. Ishizaka, K.: "Structure and Biologic Activity of Immunoglobulin E," *Hospital Practice* 12: 57, 1977.
2. Kaliner, M. and Austen, K. F.: "Immunologic Release of Chemical Mediators From Human Tissues," *Ann. Rev. Pharmacol.* 15: 177, 1975.
3. Conroy, M. C., Adkinson, N. F., and Lichtenstein, L. M.: "Measurement of IgE on Human Basophils: Relation to Serum IgE and Anti-Ig-E-Induced Histamine Release," *J. Immunol.* 118: 1317, 1977.
4. Ishizaka, T., Chang, T. H., Taggart, M., and Ishizaka, K.: "Histamine Release From Mast Cells by Antibodies Against Rat Basophilic Leukemia Cell Membranes," *J. Immunol.* 119: 1589, 1977.
5. Kaliner, M.: "Human Lung Tissue and Anaphylaxis. The Role of Cyclic GMP as a Modulator of the Immunologically Induced Secretory Process," *J. Allergy Clin. Immunol.* 60: 204, 1977.
6. Hastie, R., Chir, B., Levy, D. A., and Weiss, C.: "The Antigen-Induced Degranulation of Basophil Leukocytes from Atopic Subjects Studied By Electron Microscopy," *Lab. Invest.* 36: 173, 1977.
7. Kaliner, M.: "Human Lung Tissue and Anaphylaxis. Evidence That Cyclic Nucleotides Modulate the Immunologic Release of Mediators Through Effects on Microtubule Assembly," *J. Clin. Invest.* 60: 951, 1977.
8. Bach, M. K., Brashler, J. R., and Gorman, R. R.: "On the Structure of Slow Reacting Substance of Anaphylaxis: Evidence of Biosynthesis from Arachidonic Acid," *Prostaglandins* 14: 21, 1977.
9. Goetzl, E. J., and Austen, K. F.: "Purification and Synthesis of Eosinophilic Tetrapeptides of Human Lung Tissue: Identification as Eosinophil Chemotactic Factor of Anaphylaxis," *Proc. Natl. Acad. Sci.* 72: 4123, 1975.
10. Wasserman, S. I., Soter, N. A., Center, D. M., and Austen, K. F.: "Cold Urticaria. Recognition and Characterization of a Neutrophil Chemotactic Factor Which Appears in Serum During Experimental Cold Challenge," *J. Clin. Invest.* 60: 189, 1977.
11. Kimoto, M., Kishimoto, T., Naguchi, S., Watanabe, T., and Yamamura, Y.: "Regulation of Antibody Response in Different Immunoglobulin Classes," *J. Immunol.* 118: 840, 1977.
12. Tada, T.: "Regulation of Reaginic Antibody Formation in Animals," *Prog. Allergy* 19: 122, 1975.
13. Chiorazzi, N., Tung, A. S., and Katz, D. H.: "Induction of a Ragweed-Specific Allergic State in Ir-Gene-Restricted Nonresponder Mice," *J. Exper. Med.* 146: 302, 1977.
14. Rocklin, R. E.: "Histamine-Induced Suppressor Factor (HSF): Effect on Migration Inhibition Factor (MIF) Production and Proliferation," *J. Immunol.* 118: 1734, 1977.
15. Suemura, M., Kishimoto, T., Hirai, Y., and Yamamura, Y.: "Regulation of Antibody Responses in Different Immunoglobulin Classes," *J. Immunol.* 119: 149, 1977.
16. Blaylock, W. K.: "Atopic Dermatitis: Diagnosis and Pathobiology," *J. Allergy Clin. Immunol.* 57: 62, 1976.
17. Saraclar, Y., McGeedy, S. J., and Mansmann, H. C.: "Lymphocyte Subpopulations of Atopic Children and The Effect of Therapy Upon Them," *J. Allergy Clin. Immunol.* 60: 301, 1977.
18. Nakajima, S., Gillespie, D. N., and Gleich, G. J.: "Differences Between IgA and IgE as Secretory Proteins," *Clin. Exper. Immunol.* 21: 306, 1975.
19. Gonzalez-Molina, A., and Spiegelberg, H. L.: "A Subpopulation of Normal Human Peripheral B Lymphocytes That Bind IgE," *J. Clin. Invest.* 59: 616, 1977.
20. Nisonoff, A., and Bangasser, S. A.: "Immunological Suppression of Idiotypic Specificities," *Transplantation Rev.* 27: 100, 1975.



Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 6, 1978.

Case Report:

Constrictive Pericarditis

Dr. Howard Pitluk: A 56-year-old man began noticing shortness of breath and dyspnea three years ago. On exertion, these symptoms became markedly worse three months ago, with swelling of the abdomen. He also had marked peripheral edema. He was admitted to another hospital with a diagnosis of congestive heart failure. With therapy, he had diuresis, a 30-pound weight loss and marked relief of his dyspnea and edema. His abdominal girth decreased and hepatomegaly was detected. The liver margin was 7cm below the costal margin, with an overall span of 16cm. He admitted to the ingestion of a fifth of alcohol in beverage daily. A liver biopsy demonstrated fibrosis but was non-specific.

Past history did not include tuberculosis or other specific infections or previous cardiac disease. Chest X-ray and echocardiogram at this hospital suggested the presence of constrictive pericarditis and he was referred to the Northwestern Memorial Hospital. His medications included Lasix® and digoxin. Family and social history were non-contributory. When physical examination was performed, he was found to be a well developed man with a blood pressure of 110/60. Pulse was 87 and a paradoxical pulse was not detected. Cardiac examination revealed a diastolic murmur with the S3 sound. His abdomen was markedly distended. The liver margin was 6cm below the costal margin with an overall span of 15cm. There was 2+ pitting pretibial edema. Peripheral pulses were present and normal. Standard laboratory studies were within normal limits.

Chest X-ray was abnormal.

Dr. Melissa Riedy: The PA film showed an enlarged cardiac silhouette and one area appeared to be calcified. There was a right pleural effusion, and pulmonary vascularity was increased in the upper lung fields. The lateral view showed a curvilinear calcification conforming to the pericardium. (Figure 1). These findings suggested constrictive pericarditis. Fifty percent of patients with constrictive pericarditis will have calcification of the pericardium and cardiomegaly may be found in some patients, although a small cardiac silhouette is more common.

Dr. Howard Pitluk: Cardiac catheterization was performed and was consistent with the diagnosis of constrictive pericarditis. The patient was taken to the operating room and a thoracotomy was performed. A calcific pericardium was found. The thickened, calcified pericardium was dissected from the epicardium which was densely scarred and made dissection extremely difficult. Sufficient pericardium was removed to release the heart and provide adequate diastolic expansion of the ventricles. He recovered well.

History

The history of the disease begins in 1842, when N. Chevers of Guys Hospital first described the clinical picture of constrictive pericarditis. However, it was in 1896 that F. Pick in London described constrictive pericarditis, which became known as Pick's disease. It has been reported that Dr. Pick described a small, quiet heart as one of

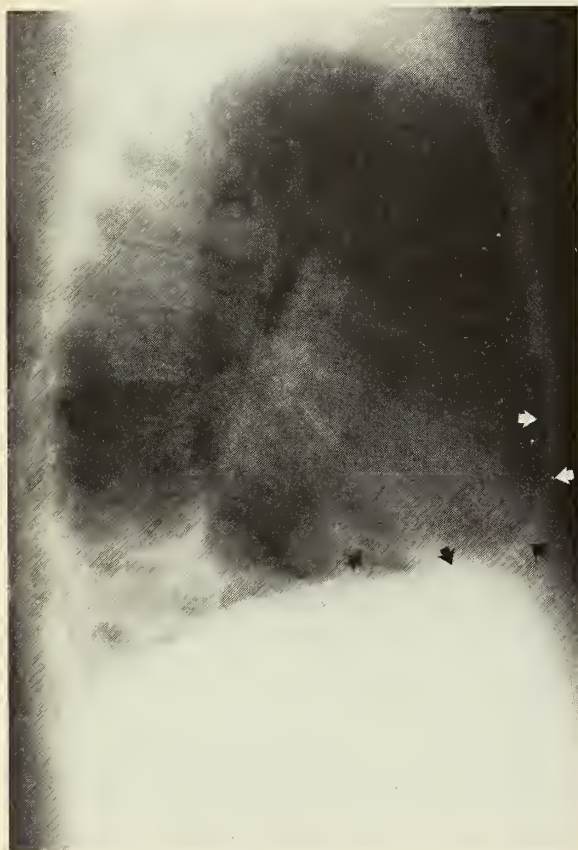


Figure 1

The calcified border of the pericardium was seen best on the lateral chest film.

the hallmarks of physical findings. Dr. Pick had a very large heart and died in 1926 at the age of 59 years. His autopsy disclosed that he had died of constrictive pericarditis, undiagnosed. In 1935, Dr. Paul Dudley White, Boston, presented the classic description of constrictive pericarditis. He described the clinical, pathological, and physiological concepts which remain pertinent. Churchill (1929) performed the first successful pericardiectomy for constrictive pericarditis in the United States.

Clinically, the patient is usually in the second to seventh decade of life and males predominate 2:1. Symptoms include dyspnea, weakness and fatigue. Ascites is commonly present. The hallmark of physical examination is increased venous pressure, even after adequate diuresis. Typically, the heart is quiet and the apical beat may not be felt. Hepatomegaly and ascites are often present. Paradoxical pulse may be present, disappearing during inspiration. A narrow pulse pressure is common.

Differential Diagnosis

The chest X-ray may reveal a heart shadow that is normal or slightly enlarged. A rim of calcification may be seen on the lateral chest film, which greatly aids the diagnosis. The electrocardiogram is not specific, though abnormal. The QRS complex usually show low voltage, and T waves are often flat and inverted. Atrial fibrillation is present in many. Diagnosis may be quite difficult. The most important aspect of diagnosis is to differentiate pericarditis from myocardial disease. Cardiac catheterization is a helpful technique. The essential feature of constrictive pericarditis is the limitation of diastolic filling during the cardiac cycle.

Several findings are important in differentiating constrictive pericarditis from cardiomyopathies. The first is cardiac output. Myocardial disease is often associated with decreased cardiac output, while constrictive pericarditis does not primarily affect the cardiac muscle, so that cardiac output is not significantly altered. Our patient's cardiac output was 6 liters per minute as calculated, which is consistent with his habitus. Second, pulmonary wedge pressure usually will be increased in cardiomyopathies, but marginally increased in constrictive pericarditis; again, our patient had this finding. Another important finding is the difference between the right atrial and the left atrial pressures. In constrictive pericarditis, the difference is less than 6 mmHg, but greater than 6 mmHg in myocardial disease. Our patient's difference was about 4 mmHg. The ratio of the pulmonary artery systolic pressure with the right atrial mean pressure approaches 1 in constrictive pericarditis. If the ratio is less than 3.5, constrictive pericarditis is probably present; when greater than 3.5, myocardial disease is likely. These findings can be obtained with a Swan-Ganz catheter, so that the use of angiocardiology usually is unnecessary. Angiograms are helpful if you want to look at the right heart border to determine thickening, straightening, or decreased motion of the border, which add supportive evidence to the diagnosis.

Etiology

Multiple etiologic factors have been implicated in chronic constrictive pericarditis. Tuberculosis was thought the most common cause in the past. However, the incidence of tuberculosis has decreased while pericarditis continues to occur at approximately the same rate. The treatment of chronic constrictive pericarditis is essentially surgical. The timing of surgery is dependent upon the condition of the patient and the symptoms he

manifests. Our patient probably had constrictive pericarditis for several years, but only decompensated recently. During the 1930's, the mortality rate for operation ranged from 25-50%, with only a 40% improvement. The mortality rate dropped after 1950 and since 1960 has remained at approximately 5%, with a 90% cure rate. Improvement begins about 4 days after operation with a gradual decrease of venous pressure toward normal, so that approximately one month later, the patient has regained his usual state of well being.

The surgical approach is usually through a median sternotomy or a left thoracotomy.

Dr. Arthur DeBoer: There is very little to add to the complete discussion of Dr. Pitluk; however, a few points might be emphasized. Certainly from a general surgeon's point of view, constrictive pericarditis should be included in the differential diagnosis for anyone who has hepatomegaly and ascites. These two findings are almost sure to be present when a constrictive pericarditis is hemodynamically significant. If the patient has, in addition, engorged neck veins and evidence of heart failure, constrictive pericarditis is very high on the priority list of possible diagnoses. The chest X-ray is frequently of additional help in that the cardiac silhouette is normal or smaller than normal in size, and if the epicardial sac is calcified as it was in the patient discussed today, the diagnosis is almost certain to be constrictive pericarditis rather than primary liver disease. As Dr. Pitluk mentioned, in the past, the etiology of constrictive pericarditis was felt to be tuberculous almost exclusively; however, today there is considerable evidence to suggest that any severe pericarditis or myocarditis can cause constrictive pericarditis. The more common etiology of pericarditis today is probably viral, rather than tuberculous in origin. However, it is exceedingly unusual for a bacterial pericarditis to produce constrictive pericarditis.

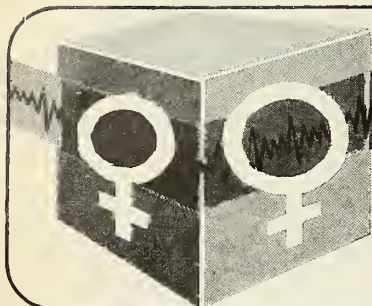
In view of the fact that the surgical procedure can be rather long, tedious and difficult when the sac is calcified and virtually glued to epicardium, some centers have suggested that a pericardectomy should be done prophylactically following a documented tuberculous pericarditis. My impression is that although the surgical procedure is certainly easier in the early stages of the adhesive pericarditis, I am not sure that this is a realistic approach. The surgical approach and technique varies, as do surgeons, but it has been quite well documented that if the pericardial sac is removed phrenic nerve to phrenic nerve, the end results almost always are good. ▲



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MRS. EUGENE VICKERY, Editor



Growth Patterns

District Five Reports

BY MRS. R. M. REARDON, FIFTH DISTRICT COUNCILOR

MRS. EARL V. KLAREN, PRESIDENT, ISMSA

Encompassing the counties of DeWitt, Logan, Mason, McLean, Menard, Montgomery, Sangamon and Tazewell, District 5 of the Illinois State Medical Society Auxiliary is truly in the heartland of the state of Illinois. This is a remarkably diverse district, where we find the seat of our state government, home offices or branches of large corporations, a medical school, a large state university, several fine smaller colleges, and the farming industry as a common thread. An exciting combination of progress and solidarity exists here.

So it also is in the District 5 medical community. Three counties have organized auxiliaries, representing a total of 123 years' activity. McLean County, the first county auxiliary in Illinois, met originally in September, 1927. This group disbanded in 1941, and reorganized in 1949. Sangamon County chose Valentine's Day of 1929 to organize, and Tazewell County organized their

auxiliary in 1947. There are 11 Members-at-Large in the district, many of whom attend some meetings of the organized counties. At present, a fourth county is considering organization.

The activities of auxiliary members are as diverse and vital as the areas which they represent. Each auxiliary seems to tailor its activities to regional needs. The programs they sponsor aim toward service and dissemination of information.

McLean County

McLean County recently sponsored a lecture by a professor from Illinois State University on "Religious Cults." The program proved most timely and appropriate in a college community where recruiters for these organizations are active. A program concerning drugs is planned. This auxiliary is making a special effort to inform its 93

members and the community about the Hospice program. Each year McLean County has sponsored a social function with an international flavor. A fund raiser for Benevolence or other causes, this has been either a luncheon or dinner. Each person is asked to contribute a dish native to their heritage and to wear native costumes if they have them. Always a festive occasion, it has provided an opportunity for a melding and understanding of the various cultures represented by the numerous doctors' families from foreign countries who have located in McLean County.

Sangamon County

Sangamon County has made a particular effort to become acquainted with the medical school in Springfield and to acquaint personnel with their activities. The present 150 members have developed a "Big-Sister" program to help potential members and offer them assistance getting settled in the community. Because Springfield is located in Sangamon County, members are frequently asked to assist with statewide programs. They will represent the auxiliary at a PTA health seminar in March, and will assist with the Legislative Conference in April.

Tazewell County

Tazewell Auxiliary has formed the "Tazewell County Auxiliary-Peoria School of Medicine Student Loan Fund." This loan is available to students who are interested in coming to Tazewell County in the field of family practice. In September, the Auxiliary sponsored an elegant luncheon-fashion show to raise money for this fund. Their profit from this one event was over \$1000—no small feat for an organization of only 30 members. Tazewell members have recognized the adjustment necessary for those moving from urban areas to rural areas and have extended their help to new administrators at Pekin Hospital so that new M.D.'s could more easily become acclimated to their community. In addition, Tazewell has adopted a needy family to help in their area.

All three auxiliaries continue to encourage their membership to receive CPR training and have distributed Heimlich posters in the communities. McLean County purchased an "Annie" and an infant doll which will be donated to the CPR training programs there. Each of the auxiliaries work diligently for Benevolence, AMA-ERF, and local Student Loan or Scholarship Funds. The methods of fund raising have ranged from very popular potluck dinners to large rummage sales, to teas where Christmas Cards and other ERF sale items were displayed.

However, there are problems expressed by the auxiliaries. Some solutions have been found. Sangamon County now uses a "piggyback" mailer which has helped improve attendance at meetings. McLean County does not use joint billing, but finds that an envelope pre-addressed to the Treasurer aids collection of dues. Sangamon has not been able to receive publicity in the local newspaper, a problem that remains unresolved there and periodically exists for the other auxiliaries. Another continuing problem is how to broaden the involvement and enthusiasm beyond a nucleus of very active members. Solutions are still being sought.

It is not all work and no play in District 5, however. Each county sponsors a festive occasion shared with the doctors, usually in the form of a dinner dance. Members enjoy the opportunity for older families to meet newer members and for the camaraderie produced through a pleasant atmosphere.

In sum, our auxiliaries in District 5 are extremely active, expanding their individual knowledge, furthering the general health of the area, and lending support to the medical community. ◀

Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

1979 Spring Course Schedule

ADVANCES IN SURGERY, April 9-13
SPECIALTY REVIEW IN UROLOGY, April 9-13
STATE & NATIONAL BOARD REVIEWS
BASIC, April 16-22; CLINICAL, April 23-28
RADIATION ONCOLOGY, April 23-27
GENERAL & DIAGNOSTIC RADIOLOGY, April 23-27
SPECIALTY REVIEW IN OB-GYN, April 30-May 11
SPECIALTY REVIEW IN FAMILY PRACTICE, May 7-18
SPECIALTY REVIEW IN ANESTHESIOLOGY, May 13-18
REVIEW IN MEDICAL SUBSPECIALTIES, May 7, 14, 21
SPECIALTY REVIEW IN PEDIATRIC CARDIOLOGY,
May 23-25
REFRESHER IN DIAGNOSTIC RADIOLOGICAL PHYSICS,
June 4-9
CARDIOLOGY FOR THE INTERNIST, June 7-8
CURRENT CONCEPTS IN MANAGEMENT OF
COMMON NEOPLASMS, June 11-13
FLUIDS & ELECTROLYTES, June 14-16

For further information and course offerings,
please write:

Registrar

**Cook County Graduate School of Medicine
707 South Wood St., Chicago, Illinois 60612
(312) 733-2800**

(Continued from page 142)

Answers: 1. C, D. 2. E.

The ECG shows a tall R wave in lead V₁ measuring 11mm. and severe right axis deviation. The mean QRS axis in the limb leads is directed toward the right arm at approximately -140°. Tall P waves in lead II measure 3.0-3.5 mm. for a diagnosis of right atrial enlargement. This ECG suggests systemic pressure in the right ventricle. A symptomatic, cyanotic patient with this ECG requires cardiac catheterization for a full cardiac evaluation. The catheterization did demonstrate the findings of Tetralogy of Fallot as described previously. No pulmonary outflow tract could be found. This was a case of pulmonary atresia or "pseudo-truncus arteriosus." The catheter was advanced into a large right subclavian artery which was connected to the main pulmonary artery. The pressure in the pulmonary artery was 90/60mm.Hg. while aortic pressure was 110/50mm.Hg. From 1945 onward, these patients could be offered surgery to improve pulmonary blood flow, the Blalock-Taussig procedure. Our patient's surgery had been performed by Dr. Blalock, who initiated the right subclavian to main pulmonary artery anastomosis nearly 32 years ago. (Reference, Blalock, A., Taussig, H.B.: *JAMA* 128:189, 1945).

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ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for 1979:

May 19-June 1—Adriatic/Greek Isles Cruise (Venice-Dubrovnik-Athens)

June 24-July 5—Rhine Cruise (Munich, Rhine River, Brussels)

July 30-Aug. 12—European Adventure (Paris, Interlaken, Florence)

Sept. 2-15—Danube Cruise (Vienna to Istanbul)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

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Abstracts of Board Actions

(Continued from page 141)

Generic Substitution

To ensure that patients benefit from the state's drug substitution law and to prevent unauthorized substitution, ISMS will urge members to have the following patient message imprinted on prescription pads:

If 'may substitute' is checked, please have the pharmacist assure you that the medicine dispensed is in the Illinois Drug Substitution Formulary, and there is a cost savings to you.

In November, ISMS requested that the Ill. Dept. of Public Health mandate use of a Society-developed patient consent form via regulations governing the substitution law. The form is designed to be signed by the patient to authorize substitution of a generic drug. Because IDPH has not yet officially responded to the request, ISMS again will urge IDPH to adopt the form. If IDPH does not mandate use of the form, ISMS may seek legislation requiring its use.

Minimum Health Insurance Standards

ISMS will discontinue efforts to revise its *Minimum Standards for Health Insurance Programs* because: (1) The Ill. Dept. of Insurance has promulgated regulations defining what minimum benefits health and accident policies must contain and requiring policies to explain specifically what is—and is not—covered; and (2) AMA has published a booklet outlining health insurance concepts.

Lay Persons in Delivery Rooms

ISMS will inform the Ill. Commission on the Status of Women—which favors family-centered obstetric care—of the Society's position concerning family members being permitted in the delivery room during normal births. That position—reaffirmed by the Board—states:

No lay visitor shall be given access to the operating room during surgery. The presence of the father of the baby in the delivery room shall be discretionary with the individual hospital. If the father of the baby is to be admitted to the delivery room of any hospital, the hospital shall first have adopted a policy statement on the matter which, among other things, establishes the following conditions: (1) Written consent of both the mother and the attending physician; (2) Prior orientation preparation of the father and mother of the baby to this experience; and (3) Application of safeguards against the introduction of infection or other hazard by the father of the baby.

The Ill. Dept. of Public Health will be notified of the Society's strong opposition to the policy of permitting—under any circumstances—lay personnel in hospital surgical suites when caesarean sections or any major surgery is being performed. Current IDPH regulations permit the exclusion of lay persons from hospital surgical suites. However, Ill. Hospital Licensing Board has adopted guidelines that permit a father to witness a caesarean section delivery, provided the hospital meets certain requirements.

Alcoholism Education

ISMS will encourage all Illinois county coroners and medical examiners to routinely determine the blood alcohol levels in victims of violent, traumatic death. If coroners and examiners agree to collect the information, ISMS will analyze the data for possible use in developing physician and patient education materials.

The Society also will sponsor:

- An alcoholism seminar during the ISMS annual meeting in May. The program is expected to focus on diagnosis and treatment of alcoholism in teenagers, and will offer hour-for-hour CME Category 2 credit. Details will be announced in the near future.
- An exhibit at the Ill. State Fair this summer presenting information on alcoholism and offering screening for hypertension.

Both the seminar and State Fair exhibit will be produced under a grant from the Ill. Dept. of Mental Health and Developmental Disabilities' Division of Alcoholism.

EMT-A Training

ISMS will urge the Ill. Dept. of Public Health to refrain from administering pilot EMT-A certification tests to EMT-A students unless they already have passed the state certification exam. The action was prompted by concern over the quality and appropriateness of the pilot exam. ISMS also will urge IDPH to refer proposed changes in EMT-A training requirements to ISMS for appropriate professional review and comment.

Minority Enrollment In Medical Schools

ISMS will cooperate with a consortium—composed of representatives from Chicago-area medical schools—devoted to developing programs that will encourage minority high school students to pursue careers in medicine. ISMS will appoint a representative to participate in consortium activities. These activities may be expanded to include assistance to students electing to pursue careers in various health professions.

IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Diulo (Metolazone), Clinoril (Sulindac), Duricef (Cefadroxil Monohydrate), Topicycline, Cardioquin Tablets, Trilisate, Nylmerate II Solution Concentrate, Timolol (Timoptic), Rocaltrol (Calcitrol), Lopressor (Metoprolol), Didronal (Etidronate), Nolvadex (Tamoxifen), Ilosone (Erythromycin Estolate), Erythrocin (Erythromycin Sterate), and Erythromycin Base.

Appointments/Nominations

The Board approved the following appointments to ISMS committees:

- *Dr. Gerald Modjeska*, Chicago—Insurance Committee
- *Drs. Marshall Short*, River Forest, and *John Dietrich*, Springfield—Laboratory Services Committee
- *Drs. James Reeder*, Park Ridge; *Daniel Bloomfield*, Champaign, *John Dietrich*, Springfield; and *Ronald Johnson*, Carbondale—Committee to Coordinate Local Student Business Session & Resident Physicians Section Activities
- *Dr. Donald Aaronson*, Niles—Judicial Panel. Dr. Aaronson—filling a vacancy created by the resignation of Dr. Herschel Browns, Chicago—will serve as an “acting member” until the ISMS annual meeting.

Reappointed ISMS representatives for 1979 to the 37-member Board of Directors of the Ill. Co-operative Health Data Systems, Inc. were: *Drs. Audley Connor*, Chicago; *Alexander Goldstein*, Harrisburg; *Allan Goslin*, Streator; *Donald Hanscom*, Hinsdale; *Henrietta Herbolsheimer*, Chicago; *Joseph O'Donnell*, Glen Ellyn; *Clifton Reeder*, Chicago; *Ben Williams*, Urbana . . . and Messrs. *Roger White* and *Joel Edelman*. Newly-appointed to the group was *Dr. Walter Stevenson, III*, Quincy

The Board approved the following appointments of ISMS representatives to other groups:

- *Dr. William Lees*, Lincolnwood—Board of Trustees, Illinois Cancer Council
- *Drs. Allan Goslin*; *Risher Watts, Jr.*, Chicago; and *Loren Boon*, Danvers—ISMS-Illinois Nurses Association Joint Practice Committee
- *Drs. David Fox*; *Alex Spadoni*, Joliet; *Arthur Traugott*, Urbana; and *Robert Hartman*—Task Force on the Mental Health Code which was created to analyze the code and devise strategy to obtain necessary changes. The Task Force also consists of IDMHDD Dir. Dr. Robert DeVito and representatives from the Illinois Psychiatric Society and other psychiatric groups.
- *Dr. Larry Plummer*, Jerseyville—1979 AMA National Conference on Rural Health

The Board also agreed to support *Dr. Frank Jirka, Jr.*, Barrington, for re-election to the AMA Board of Trustees. Nominated for AMA posts were: *Dr. David Fox*—Council on Legislation; and *Dr. Robert Hartman*—Ad Hoc Committee on Maternal, Adolescent and Child Health.

Acting as corporation members of ICCME, the ISMS Executive Committee named the following as ISMS representatives to the ICCME Board of Trustees: *Drs. Kenneth Hurst, Naperville; Alfred Kiessel, Decatur; Fred White, Chillicothe; E. Chester Bone, Jacksonville; Dean Bordeaux, Peoria; Alfred Clementi, Arlington Heights; William Lees, Lincolnwood; Boyd McCracken, Greenville; and Donald Pochyly, River Forest.* Upon nomination of their respective medical schools, the following were elected to the ICCME Board as representatives of those schools: *Drs. Anthony Barbato, Loyola Stritch School of Medicine; Chase Kimball, Pritzker School of Medicine, Univ. of Chicago; Harold Paul, Rush Medical College; Jacob Suker, Northwestern Univ. School of Medicine; and D. Dax Taylor, So. Ill. Univ. School of Medicine . . . and Ben Blivaiss, Ph.D., Chicago Medical School; Thomas Henderson, Ph.D., Univ. of Ill. College of Medicine; and Ward Perrin, D.O., Chicago College of Osteopathic Medicine.*

A special committee was formed to select ISMS nominees for the All-American Medical Hall of Fame. The Hall of Fame—created by the St. Louis Medical Society—is designed to honor physicians for outstanding work in office practice, teaching, research, and hospital, government or medical society service. Named to the nominating committee were: *Drs. Joseph Kiefer, Chicago; Walter Palmer, Chicago; and Emmet Pearson, Springfield.*

Study FTC Actions/Hospital-Initiated Suits

The ISMS president, president-elect and Board chairman—working with the ISMS executive administrator and legal counsel—will conduct a detailed study of: (1) FTC and Dept. of Justice investigations of the health field; and (2) implications of hospital-initiated suits against physicians when the hospital named in a malpractice suit is required to pay damages and now seeks contributions from the doctor for his alleged part in the malpractice occurrence.

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312/782-1963

Dear Colleague:

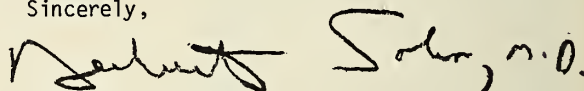
It's not too late. As a matter of fact, the time is just right for you to begin to think about the 1980 elections. Some of you may have been dissatisfied with the results of the 1978 elections. Candidates you believed in may have lost; others you thought should have lost may have won. Those situations fall under the category of "personal tragedies".

There is, however, a greater tragedy -- both for you and for the future of our country -- if you didn't vote or, worse still, if you aren't registered to vote. You have no role to play in our system of government if you aren't registered. You have little reason to complain if government doesn't act the way you think it should if you don't vote.

That's why I say that the time is right to think about 1980. You can start the political process by registering. Each county in this state has a County Clerk, one of whose responsibilities is voter registration. At any time during regular business hours, you can go to the Clerk's office and register in person. Or you can call the Clerk who will be happy to explain any other arrangements which can be made -- such as precinct registration days during which you can register at your local polling place.

Remember, your local communities, park districts, school boards and other units of local government are elected during the off years -- and not necessarily in November. Register now so that you can begin to impact on your own community. That impact can carry over to the state and federal level.

Sincerely,



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Viewbox

(Continued from page 145)

DIAGNOSIS: Neuroblastoma—The neuroblastoma is the most common malignant retroperitoneal tumor in infants and children. It is predominantly a disease of the young, with about 90% of the cases seen by age eight. It is essentially an extrinsic rather than an intrinsic renal tumor. The typical urographic appearance is the angular displacement of the kidney, in this case downward and laterally, with no distortion of the pelvis and calices in the usual case. Calcification in the tumor is helpful, as it is relatively common, about 50% in neuroblastoma, but rare in Wilm's tumor. They frequently metastasize to bone, mesenteric and aortic lymph nodes. Biochemical assays of the urine for the metabolites of the catecholamines and VMA are extremely helpful in the diagnosis. In Fig. 1, IVP reveals a mass compressing the

kidney laterally, questionable calcifications are noted beneath the greater curvature of the stomach. There is also noted a displacement bilaterally of the paravertebral shadow at the level of T-10, 11 and 12. Figure 2 and 3 CT scan confirms the presence of retrocrural nodes and scattered amorphous calcifications. Figure 3 demonstrates the marked displacement of the left kidney by the mass which encases the aorta and displaces the left ureter medially and anteriorly. There is a belief that resection of the tumor improves the prognosis even if it is only partial in nature. The CT scan demonstrates the bulk of the mass and the difficulty which was encountered at surgery. Arrows are on the retrocrural nodes and tumor mass with calcifications. *Neuroblastoma, adrenal and paraaortic nodes.* ◀

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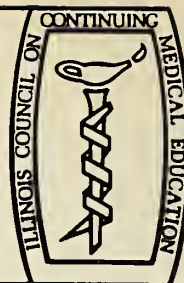
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ISMS Guide to Continuing Medical Education

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

APRIL

Allergy

MPE 908: A CLINICAL APPROACH TO ALLERGIC DISORDERS

For: FP's, GP's, Internists. Conference/workshop, April 26-27, St. Louis, Missouri. Speaker: Raymond G. Slavin, MD. Sponsor: St. Louis University School of Medicine, Medical Center Continuing Education, 1402 S. Grand, St. Louis, Missouri 63104. Cosponsors: South Central Regional Medical Education Center; Veterans Administration, St. Louis. Fee: \$125. Reg. limit: none. Credit: AMA Category 1, 17 hours. Contact: John Grellner. Phone: 314-664-9800 x 127.

Diabetes

THE CONTINUING CARE OF THE DIABETIC PATIENT

For: primary care physicians. Symposium, April 18, 3:00-7:30 p.m., Urbana. Sponsor: Carle Foundation Hospital, 611 W. Park, Urbana 61801. Cosponsor: School of Clinical Medicine, University of Illinois. Reg. deadline: 4/12. Fee: \$20. Reg. limit: none. Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Contact: Deborah Rugg. Phone: 217-337-3022.

Environmental Health

INDUSTRIAL MEDICINE AND TOXICOLOGY

For: MD's. Lecture/discussion, April 18, 1:30-3:30 p.m., Rockford. Speaker: Raymond Suskind, M.D. Sponsor: Rockford School of Medicine, Office of the Dean, 1601 Parkview Ave., Rockford 61101. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours. Contact: M. W. McLeod. Phone: 815-987-7226.

Family Medicine

EVALUATION OF HYPERTENSIVE PATIENT

For: MD's. Lecture, April 17, 7:30 p.m., Elgin. Sponsor: Sherman Hospital, 934 Center St., Elgin. Fee: none. Credit: AMA Category 1, 2 hours. Contact: Mary Anne Stiegemeier. Phone: 312-742-9800 x 649.

Internal Medicine

REVIEW OF MEDICINE

For: Internists, GP's. Lecture, monthly, Wednesdays, 8:00 a.m., Chicago. Sponsor: Weiss Memorial Hospital, 4646 N. Marine Dr., Chicago 60640. Fee: none. Reg. limit: none. Credit: AMA Category 1, 2 hours. Contact: D. Mehta, MD. Phone: 312-878-8700.

Internal Medicine

MASKS OF PORTAL-SYSTEMIC ENCEPHALOPATHY AND PORTAL HYPERTENSION SYNDROME

For: MD's, DDS's, pharmacists, nurses. Seminar, April 4, Waukegan. Sponsor: St. Therese Hospital, 2615 W. Washington, Waukegan 60085. Reg. deadline: 4/2. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours. AOA, 5 hours. Contact: R. M. Adelman, MD. Phone: 312-688-5800.

Medical History

THE DOCTOR'S IMAGE REFLECTED IN THE MATULA

For: all interested in medical history. Lecture, April 25, 1:00 p.m., Chicago. Speaker: Joseph Kiefer, MD. Sponsor: University of Illinois College of Medicine, Dept. of Surgery, P.O. Box 6998, Chicago 60680. Fee: none. Credit: none. Contact: Elaine Wilcox. Phone: 312-996-6771.

Medicine

HOLISTIC APPROACH TO CARE OF CANCER PATIENT

For: MD's, DDS's, RN, R PH. Seminar, April 18, Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan 60085. Reg. deadline: 4/16. Fee: \$3. Credit: AMA Category 1, 5 hours; AOA, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312-688-5800.

Ophthalmology

FOURTH ANNUAL EYE, EAR, NOSE AND THROAT SYMPOSIUM

For: MD's. Symposium, April 28, 9:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Credit: AMA Category 1, 6 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Psychiatry

PSYCHIATRY BOARD PREPARATION:

PART II

For: candidates for Board Examination. Discussion groups, April 16-17, 9:00 a.m.-5:00 p.m., Chicago. Sponsor: University of Chicago, Depts. of Psychiatry and Neurology, 950 E. 59th St., Chicago 60637. Fee: \$200. Reg. limit: 60. Credit: AMA Category 1, 14 hours. Contact: John Crayton, MD. Phone: 312-947-6415.

Surgery

VISITING PROFESSORS LECTURE SERIES

For: MD's. Lectures, Jan-June, Wednesdays, 9:00 a.m., VA Hospital, North Chicago. Speaker: William Schumer, MD. Sponsor: St. Mary of Nazareth Hospital Center, 2233 W. Division, Chicago. Fee: none. Reg. limit: 100. Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours. Contact: Anthony Sapienza, MD. Phone: 312-770-2060.

Surgical Pathology

SURGICAL PATHOLOGY LECTURE SERIES

For: MD's. Lectures, Jan-May, Tuesdays, 8:30 a.m., Chicago. Speaker: Walter Kawula, MD. Sponsor: St. Mary of Nazareth Hospital Center, 2233 W. Division, Chicago. Fee: none. Reg. limit: 100. Credit: AMA Category 1, 1½ hours; AAFP Elective, 1½ hours. Contact: Anthony Sapienza, MD. Phone: 312-770-2060.

Surgery

BASIC SCIENCE LECTURES

For: MD's. Lectures, Jan-June, Mondays, 8:30 a.m., Chicago. Speaker: Anthony Sapienza, MD. Sponsor: St. Mary of Nazareth Hospital Center, 2233 W. Division, Chicago. Fee: none. Reg. limit: 100. Credit: AMA Category 1, 1½ hours; AAFP Elective, 1½ hours. Contact: Anthony Sapienza, MD. Phone: 312-770-2060.

Preventive Medicine

CLINICAL TOPICS IN PREVENTIVE MEDICINE

For: MD's. Symposium, April 4, 8:00 a.m.-4:30 p.m., Chicago. Sponsor: Henrotin Hospital, 111 W. Oak St., Chicago 60610. Reg. deadline: 3/30. Fee: none. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: William Werner, MD. Phone: 312-440-7753.

MAY

Basic Audit Seminars

BASIC AUDIT SEMINAR/PSYCHIATRIC AUDIT TEAM SEMINAR

For: Medical & mental health core professionals. Seminars, May 2-3, Indianapolis, Indiana. Sponsor: Indiana Hospital Association, 3921 N. Meridian St., Indianapolis 46208. Reg. deadline: 4/20. Fee: \$170. Reg. limit: none. Credit: AMA Category 1, 13½ hours; AMRA, 13½ hours. Contact: Jessica Manson. Phone: 317-926-1395.

Family Medicine

DIABETES

For: MD's. Lecture, May 15, 7:30 p.m., Elgin. Sponsor: Sherman Hospital, 934 Center St., Elgin 60120. Fee: none. Credit: AMA Category 1, 2 hours. Contact: Mary Anne Stiegemeier. Phone: 312-742-9800 x 649.

Medicine

ARTHRITIS AND RHEUMATOLOGY

For: MD's. Symposium, May 2, 1:00 p.m., Breese. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

HYPERTENSION SYMPOSIUM

For: MD's. Symposium, May 16, 8:00 a.m., Belleville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

SAVE THE DATE

1979 ANNUAL CONGRESS ON CME

April 6-7

Oak Brook Hyatt House

"Planning a CME Program that Works—
What to Present,
Checking for Effectiveness"

Medicine

ACUTE RESPIRATORY FAILURE/CHRONIC OBSTRUCTIVE PULMONARY DISEASE

For: MD's. Symposium, May 22, 7:00 p.m., Greenville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

MULTI-DISCIPLINARY/LOW BACK PAIN

For: MD's. Symposium, May 16, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

CARDIAC ARRHYTHMIAS

For: MD's. Symposium, May 23, 6:00 p.m., Jerseyville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

RHEUMATOLOGY

For: MD's. Symposium, May 31, 7:00 p.m., Benton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

EXERCISE AND THE HEART

For: MD's. Symposium, May 31, Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

OB/GYN

PERINATAL MEDICINE

For: MD's. Symposium, May 11, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 7 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Ophthalmology

OPHTHALMOLOGY CONFERENCE

For: Ophthalmologists. Lecture, May 10-11, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$140. Reg. limit: 120. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Orthopaedic Surgery

SPORTS INJURIES III

For: MD's, coaches, trainers, etc. Symposium, May 12, 9:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 5 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Otolaryngology

HEAD AND NECK ONCOLOGY

For: Surgeons, Otorhinolaryngologists. Lecture, May 14-18, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$400. Reg. limit: 100. Credit: AMA Category 1, 35 hours; AAFP Elective, 35 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Pediatric Anesthesia

SECOND ANNUAL PEDIATRIC ANESTHESIA MEETING

For: CRNA's, MD's, residents, nurses. Symposium/lecture, May 8-10, Chicago. Sponsor: Loyola University of Chicago, Stritch School of Medicine, Div. of CME, 2160 S. First Ave., Maywood 60153. Fee: \$170. Credit: AMA Category 1, 18 hours. Contact: Linda Gunzburger. Phone: 312-531-3236.

Pediatrics

METABOLIC PROBLEMS OF THE NEWBORN

For: MD's, nurses. Symposium, May 31, St. Louis, Missouri. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. Fee: \$60. Reg. limit: 150. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Loretta Giacoleto. Phone: 314-454-3873.

Pediatrics

SPECIALTY REVIEW IN PEDIATRIC CARDIOLOGY

For: Pediatric & Adult Cardiologists. Lecture, May 23 (3 days), Chicago. Speaker: Maria Serratto, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$175. Reg. limit: 150. Credit: AMA Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Primary Care

EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT

For: Internists, GP's. Lectures/workshops, May 11-13, Chicago. Sponsor: International Medical Education Corp., 60 Inverness Drive E., Englewood, Colorado 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 15 hours; AAFP Prescribed, 15 hours; OAO, 15 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Psychiatry

PSYCHIATRIC STUDIES OF JUVENILE DELINQUENTS

For: mental health professionals. Lecture, May 9, 8:00 p.m., Offield Auditorium, Chicago. Speaker: Daniel Offer, MD. Sponsor: Institute of Psychiatry, 320 E. Huron St., Chicago 60611. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 1/2 hours. Contact: Leon Diamond, MD. Phone: 312-649-8058.

Sports Medicine

SPORTS MEDICINE—UPDATE ON CURRENT ISSUES

For: GP's. Lecture, May 9, 9:30 a.m.-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Trauma

FRACTURES AND OTHER TRAUMA

For: General/Orthopaedic Surgeons. Lectures/workshops, May 9-12, Radisson Hotel, Chicago. Speaker: Prof. Doctor Jorg Bohler. Sponsor: American College of Surgeons, 55 E. Erie St., Chicago 60611. Attn: Trauma Registration. Fee: \$175; \$60, residents. Credit: AMA Category 1, 28 hours; IAFP, 28 hours. Contact: Ralph Lidge, MD. Phone: 312-392-4320.

Trauma

23rd ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA

For: GP's, Orthopaedic/general surgeons. 3 1/2 day course, May 9-12, Radisson Chicago Hotel, Chicago. Speaker: Prof. Dr. Jorg Bohler. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 55 E. Erie St., Chicago 60611. Fee: MD's, \$185. Reg. limit: none. Credit: AMA Category 1, 28 hours; AAFP Elective, 28 hours. Contact: Ralph Lidge, MD. Phone: 312-392-4320.

JUNE

Medicine

SELECTED RECENT ADVANCES IN CLINICAL MEDICINE

For: GP's. Lecture, June 14, 9:00 a.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Chicago 60637. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Medicine

NEW TRENDS IN THERAPEUTICS

For: MD's. Symposium, June 2, 1:00 p.m., Newton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Pathology

CURRENT TOPICS IN BLOOD BANKING

For: Pathologists, medical technicians. Lecture, June 7-8, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Fee: \$120. Reg. limit: 500. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Primary Care

CARDIAC SYMPTOMS, ARRHYTHMIAS, AND HOLTER MONITORING

For: GP's, Internists. Lectures/workshops, June 15-17, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Dr. E., Englewood, Colorado 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Pulmonary Disease

DIAGNOSTIC & THERAPEUTIC DECISIONS IN PATIENTS WITH PULMONARY DISEASE

For: MD's. Course, June 6-8, Chicago. Sponsor: American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104. Cosponsors: Cook County Hospital; University of Illinois. Fee: varies. Reg. limit: 300. Credit: AMA Category 1, 18 hours. Contact: Linda Salsinger. Phone: 215-243-1200.

Rehabilitation

TOTAL MANAGEMENT OF THE STROKE PATIENT

For: MD's, residents, nurses. Course, June 4-8, Chicago. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 5/15. Fee: \$200, MD; \$100, other. Reg. limit: 100. Credit: AMA Category 1, 30 hours. Contact: Don Olson. Phone: 312-649-6179.

TWO NEW PUBLICATIONS AVAILABLE FROM ICCME

SETTING DIRECTIONS IN CME offers suggestions on how to develop goals and formulate learning objectives.

CME PLANNING CHECKLISTS offers steps in CME planning to help assure learner achievement of goals and objectives and offers model forms.

Illinois physicians may obtain a **FREE** copy by writing the title on their prescription blank and mailing it to ICCME.

The 1979 Annual Illinois Congress On Continuing Medical Education April 6-7, 1979

PLANNING A CME PROGRAM THAT WORKS

What to Present

Checking for Effectiveness

The theme of the 1979 Congress relates to the basics of CME program planning. Our goal is to enable you to secure concrete "how-to-do-it" information and ideas focused on needs-identification, educational methods, and evaluation techniques.

The Congress starts with our keynote speaker: Frederick Berg, M.D. Director of the Graduate and Continuing Education Departments, National Board of Medical Examiners. Then we're offering small-group workshops on Friday evening and Saturday.

The Annual Congress is ICCME's opportunity to help you with effective program planning and your opportunity to give us the input we need to make our services and activities relevant.

Plan to attend . . .

1979

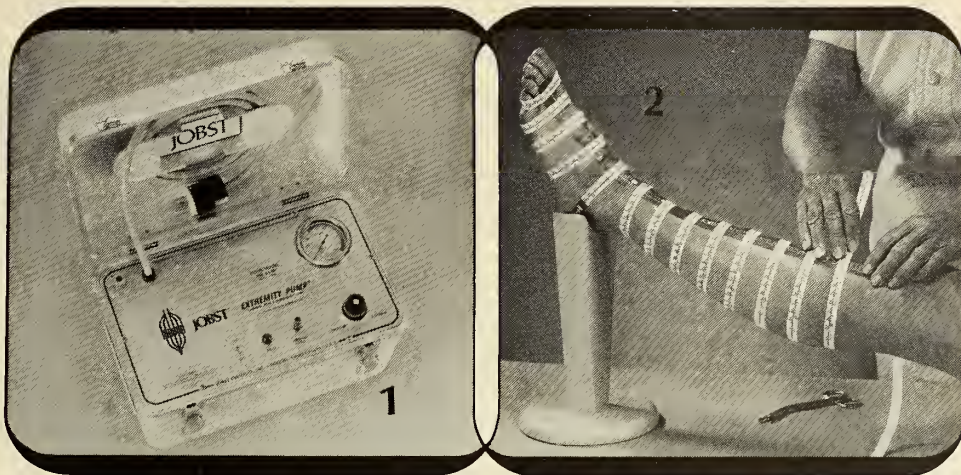
Annual Illinois Congress on Continuing Medical Education

Oak Brook Hyatt House, Oak Brook, IL

Friday, April 6, 7:00 PM—Saturday, April 7, 4:45 PM

For more information, write or call . . .

Illinois Council on Continuing Medical Education
55 E. Monroe, Suite 3510
Chicago, Illinois 60603
Telephone: (312) 236-6110



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Massive and obstinate lymphedema of the limbs may be reduced through use of the Jobst Extremity Pumps (Intermittent Compression) (photo 1). Its controlled pneumatic massage gently removes edema fluid from congested areas.

Jobst Extremity Pumps are available in hospital, clinical, and home models (shown), the latter being available on rental. All units have controls to vary both pressure

and time cycles.

When the desired reduction is attained, it can be maintained with a *Jobst Venous Pressure Gradient*® Support. These supports are custom-made to your prescription and the patient's individual measurements (photo 2). You may prescribe exact counterpressures. "In-Patient" orders will be given special attention.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BUNKER HILL: Rural community, trade area 3000. Doctor retiring. Living quarters and office space available. Excellent schools and churches. Fifty miles, north-east of St. Louis, Mo. Financial assistance available if necessary. Contact: Sally Bruckert, RR #1 Box 488, Bunker Hill 62014, phone 618-585-3192. (7)

CARBONDALE: G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

ELDORADO: Busy six-doctor practice looking for G.P./F.P., General Surgeon and Ophthalmologist. \$36,000 guaranteed first year. Located in town of 5000 in scenic southern Illinois. Call Dr. Elliott O. Partridge or Dr. Denton B. Ferrell, area code (618) 273-3361. (7)

FAIRFIELD: Need one family practitioner and one Gyn-OB man for an established two men (F.P. & Gen. Surgeon) practice in a 6500 population community. Drawing area 20,000. Excellent salary and fringe benefits. Very well equipped hospital. Excellent local schools and junior college. University 75 miles. Good recreational facilities and churches. Contact S. W. Konarski, M.D., 101 East Center Street, Fairfield, 618-842-2187. (7)

ILLINOIS: The Illinois Dept. of Corrections has immediate openings statewide for Family Practice or General Practice Physicians interested in ambulatory care. For additional information and salary schedule contact: Cecil Patmon, 160 N. LaSalle, Chicago, 60601, 312/793-3216. (6)

JACKSONVILLE: Opportunities for family practice emergency room, dermatology, OB/GYN, orthopedic surgery. Progressive 250 bed hospital, 40-member medical staff. Prosperous community with primary service area of 60,000, two colleges, excellent schools, 35 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Area Hospital, Jacksonville, 62650 (217) 245-9541. (6)

MATTOON: American trained family practitioner or internist for rewarding practice. Fully equipped office available—new 210 bed hospital (open staff)—financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient population of 75,000. Contact: A. Rauwolf, M.D., 1120 Wabash, Mattoon 61938. (217) 234-6253. (4)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity in

solo or group practice. Contact: Carol Nafziger, Minier 61759. (309) 392-2345 or 392-2120. (6)

MUNSTER, IN.: Family, ENT, Ortho.; for large mid-west multi-specialty group. Competitive first year salary with opportunity for early partnership. No investment. Most liberal vacation and P-G allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop own practice. Send C-V to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321 (219) 836-5800. (6)

PEORIA: Economically sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702). (3)

PEORIA: Orthopedic Surgeon needed in multi-specialty clinic of 12 physicians. Excellent opportunity for the right person. Located in community of 250,000, three hospitals, school of medicine. Guaranteed first year salary plus complete fringe package. Contact: Dr. R. Martin, The Medical and Surgical Clinic, S.C. 100 N.E. Randolph, Peoria, 61606. (6)

PIKE COUNTY: Population 19,000. Two general practitioners, one general surgeon, office space available beside 82 bed, JCAH, full service hospital. Financial assistance available. Ten physicians at present. Great hunting. Gary Deer, Administrator, Illini Community Hospital, 640 West Washington, Pittsfield, AC(217) 285-2113. (6)

PITTSFIELD: Family Practitioner/General Practitioner/General Surgeon to join established practice or solo. Minimum guarantee, office space available free. 82 bed JCAH full service hospital. Great bird/duck hunting. Contact Gary Deer, Illini Community Hospital, 640 W. Washington Street, Pittsfield 62363; (217-285-2113.) (7)

VALMEYER: Population 1000 with patient population of 3-4000. Scenic town on small lake. 25 miles from Belleville or Red Bud, 35 miles from St. Louis, Mo. Only physician is about to retire. Fully equipped 4 room office building for rent. Contact: H. A. Reichel, M.D., 206 W. Main, Valmeyer, IL 62295. (618) 935-2216. (6)

VANDALIA: County Hospital, serving population 25,000. Seven physicians at present. Sixty miles east of St. Louis on Interstate Highway I-70. Office space available on hospital campus. Financial assistance and deferred compensation agreements available. Contact John R. Leckrone, Administrator, Fayette County Hospital, 7th & Taylor, Vandalia 62471. (618) 283-1231. (7)

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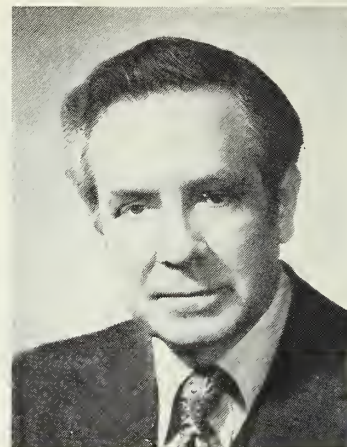


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PHARMACEUTICALS



The Voluntary Effort: A Test Of Credibility

The Voluntary Effort (VE) to check health cost inflation is meeting its goals, but major challenges must be overcome for that success to continue.

Nationwide, the VE will at least hit its targeted two percent reduction in the 1978 rate of hospital expenditure increases. In Illinois, the results will be even better. For the first 10 months of 1978, the rate of increase was limited to nine percent, while certificate-of-need approved capital expenditures were held to \$356.9 million. Both figures better the goals set by the Illinois State Cost Containment Committee, a joint ISMS-Illinois Hospital Association group charged with implementing the VE in Illinois.

Despite the nationwide success of the VE, the Carter Administration has stepped up its push for mandatory hospital cost controls. The Administration is determined to avoid the embarrassing setback suffered last year when Congress rejected a cost cap. President Carter set the stage for the new legislative drive in his State of the Union speech . . . and HEW Sec. Califano has declared a "war on numbers" against the VE. Califano's aim is to employ statistical maneuvering that will discredit the voluntary program.

Reports indicate that the Administration's cost control legislation will call for mandatory controls to be triggered if cost increases exceed Washington's arbitrary 9.7% "voluntary" limit. The figure is significantly lower than the national VE goal of 11.6% for 1979.

Officials of the VE—directed nationally by AMA, American Hospital Association and Federation of American Hospitals—have labeled the 9.7% limit unrealistic and a threat to high quality care.

We must ensure that the VE meets its goals for 1979. The VE's success—which depends upon the cooperation of all physicians and hospitals—will demonstrate to Congress that mandatory controls are not needed.

I urge you to encourage your hospital medical staff to initiate cost-saving measures. Among the steps that can be taken are: (1) reducing hospital stays through pre-admission testing prior to elective surgery and tough utilization review; (2) performing, when possible, diagnostic and surgical procedures on an out-patient basis; and (3) reviewing standing orders or routine admission orders to eliminate those procedures that are not needed.

The stakes are high. Failure of the VE would mean much more than mandatory cost controls on hospitals. It would be a near-fatal blow to the credibility of the medical profession and hospital industry. Once our credibility is lost, we would stand little, if any, chance of blocking the drive for national health insurance and a government takeover of health care.

With your help, the VE will succeed. ◀

A handwritten signature in dark ink that reads "David S. Fox". The signature is stylized, with a large, sweeping "D" and a distinct "F".

David S. Fox, M.D., President

Doctor's News

RURAL HEALTH SPOTLIGHTED—The 32nd AMA National Conference on Rural Health is scheduled for April 18-21, 1979 in St. Paul, Minnesota. The conference is designed to provide a forum to discuss alternative methods of health care service delivery in rural areas and provide relevant CME to the rural practitioner. Sessions convene at 1:30 p.m. on Wednesday, April 18, 1979, at Radisson-St. Paul in St. Paul, Minnesota. Cost of registration is \$60 to AMA members, with reduced rates for students and housestaff. For further information, contact the AMA Department of Community Health Systems, Division of Medical Practice, 535 N. Dearborn, Chicago 60610.

In a related note, two Illinois physicians received special recognition in the February 23 edition of *AM News' Impact* section for their innovations in rural health care. Eugene P. Johnson, M.D., Casey, former ISMS secretary-treasurer, and George T. Mitchell, M.D., Marshall, were lauded for a creative rural health delivery system utilizing nursing home facilities as alternatives to hospital construction in combination with specialty support from nearby hospitals. The effort, first recognized in November with a special award from Blue Cross and Blue Shield of Chicago for "outstanding accomplishments in the private health sector," was accomplished without support from governmental or outside sources. Each medical facility was constructed beside an already existing nursing home with funds raised by the local citizens. "We don't like contractual arrangements or clinical shares of stock or related restrictions," Dr. Mitchell was quoted as saying. "Each doctor runs his own business. There are no partnerships or corporations. Of course, we do consult together and see one another's patients." The article noted that the success of their effort has spawned a similar campaign in Sullivan, Illinois, where a facility is scheduled to open late in 1979.

MENTAL HEALTH TREATMENT—The AMA will sponsor a workshop on "Physicians and Chronic Mental Patients: Potentials for Community Based Care," on May 10-11, 1979 at the Chicago Palmer House. The two day workshop is designed to provide a focus on CME priorities for physicians providing comprehensive care to patients with long-term or severe mental disabilities. Topics will include examination of current delivery systems, physician relationships with mental health and human service professionals, legal and legislative issues and economic considerations. Specific attention will be given to case management, specialty contributions as well as the role of the primary care physician. The conference is designed for a multi-specialty orientation and aid to training medical students and residents as well as persons engaged in CME programs.

For further information, contact Ms. Suellen Muldoon, Associate Director, Department of Mental Health, American Medical Association, 535 N. Dearborn Street, Chicago 60610.

A WARNING NOTE—Illinois Department of Public Health Director Paul Q. Peterson, M.D., has asked that Illinois physicians become aware of an organization called Telecommunication Services, Inc., of Wood Dale, Illinois. IDPH has received reports that the company has contacted health care providers, claiming that IDPH has worked with them in studies of internal communications and facility operation. Dr. Peterson affirmed that IDPH has disclaimed any association with Telecommunication Services, and that the matter has been referred to the Illinois Attorney General. Anyone similarly contacted is asked to notify IDPH at 535 W. Jefferson, Springfield, 62761, (217) 782-2913.

PHYSICIANS IN THE NEWS—**Louis R. Caplan, M.D.**, Chicago has been named chairman of the newly created department of neurology at Michael Reese Hospital and Medical Center. Other new appointments at Reese include **David R. Hawkins, M.D.**, as director of liaison psychiatry and **Stuart J.F. Landa, M.D.**, as chairman of the division of plastic surgery in the department of surgery . . . **Lloyd M. Nyhus, M.D.**, Northbrook, head of the department of surgery at the UI College of Medicine in Chicago, was recently elected president of the *Collegium Internationale Chirurgie Digestivae* . . . **Richard C. Schultz, M.D.**, Kildeer, chief of the division of plastic surgery in the UI Medical Center department of surgery, has been elected president of the Midwestern Association of Plastic Surgery.

The Illinois Council on Continuing Medical Education, a jointly sponsored organization of the ISMS and Illinois' eight medical schools, has elected its 1979 Board of Directors and Executive Committee. The Executive Committee consists of the officers, two other board members and the chairman of the ISMS Committee on CME Accreditation. New members are: **William M. Lees, M.D.**, Lincolnwood, president, **Donald F. Pochyly, M.D.**, Chicago, vice-president, **Ward E. Perrin, D.O.**, Chicago, secretary, **Alfred J. Clementi, M.D.**, Arlington Heights, treasurer, **Dean Bordeaux, M.D.**, Peoria, chairman of the ISMS Committee on CME Accreditation, **Harold A. Paul, M.D.**, Chicago and **Boyd E. McCracken, M.D.**, Greenville.

Harold N. Walgren, M.D., Hinsdale, was recently elected president of the Civil Aviation Medical Association. Dr. Walgren, who is also an attorney, is rated as a flight surgeon, and a senior FAA Aviation Medical Examiner . . . **Julius M. Gardin, M.D.**, Chicago, an assistant professor of medicine at Northwestern University Medical Center, was recently appointed to serve as corresponding editor for both the *Archives of Internal Medicine* and *Chest* . . . **Albert H. Slepian, M.D.**, Highland Park, received the 1978 Dermatologist of the Year Award at the annual meeting of the Dermatology Foundation in San Francisco. The Foundation is a national, non-profit health agency established to foster programs designed to improve treatment and methods of prevention of skin disease. A member of the dermatology faculty at the University of Illinois, Dr. Slepian is a former president of the Chicago Dermatological Society.

Charles Sheaff, M.D., Oak Park, has received one of three Schering Scholarships awarded by the American College of Surgeons. Dr. Sheaff, a fourth year resident in surgery at the UI Medical Center, received his M.D., from Rush Medical College and holds a Ph.D., in biochemistry from the University of Illinois Medical Center.

LEGAL PITFALLS OF MEDICAL PRACTICE is the title of a special one day seminar scheduled for April 19, 1979, at the Peoria Hilton Hotel. Co-sponsored by ISMS, the Illinois Institute for Continuing Legal Education, St. Francis Hospital-Medical Center and the Methodist Medical Center of Illinois, the American Society of Law and Medicine program will explore medico-legal pitfalls commonly encountered in five selected medical specialty groups. The session carries Category 1 CME credit, and is intended to document "the belief that an informed understanding of the inter-relationship between the two professions of medicine and law is essential to serve and protect the patient-client, who is, after all, the same person."

The registration fee for American Society of Law and Medicine members is \$40, and non-member fee is \$50. Hotel accommodations can be made by directly contacting the Peoria Hilton Hotel. For registration and further information, contact the American Society of Law and Medicine, Legal Pitfalls of Medical Practice—1979, 454 Brookline Avenue, Boston, MA 02215.

See important product information including warnings, adverse reactions, patient selection and prescribing and precautionary recommendations.

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Precautions: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

Adverse Reactions: *Gastrointestinal:* epigastric distress, nausea, vomiting. *Cardiovascular:* palpitations. *CNS:* insomnia, restlessness, irritability, convulsion.

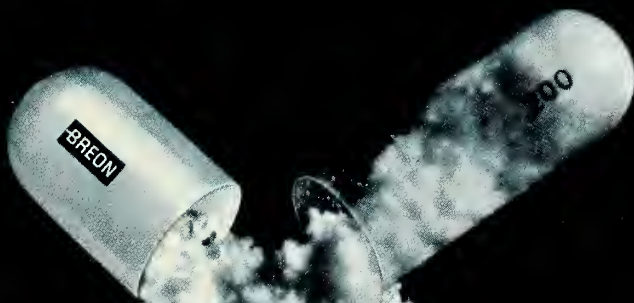
Dosage and Administration: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg./ml., but not to exceed 20 mcg./ml.

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¹ Tinkelman, D.G., Carfoll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. *Medical Challenge* 10: 24-26, 1978.

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Mr. John Robertson, Provider Service Section Supervisor, Illinois Department of Public Aid

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Application has been filed with AAMA to award CEU credits for this program. For further information please contact Vivian Kraft, CMA-AC, c/o John L. Wright, M.D., 2416 E. Washington, Suite A, Bloomington, Ill. 61701. (309) 662-1303.

For reservations, please contact Mary Lu Ostrowski, CMA, 1704 E. Jackson St., Bloomington 61701. (309) 828-4504.



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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

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Clinics for Crippled Children Listed for May

Thirty-seven clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, periatric, speech and hearing examination, along with medical, social and nursing services. There will be 26 general clinics, nine cardiac clinics and two clinics for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- May 1 Park Ridge Cardiac—Lutheran Gen. Hosp.
- May 1 Maryville—Oliver C. Anderson Hospital
- May 2 Hinsdale—Hinsdale Sanitarium
- May 2 Mt. Vernon—Good Samaritan Hospital
- May 3 Lake County Cardiac—Victory Mem. Hosp.
- May 3 Sterling—Community General Hospital
- May 3 Pittsfield—Illini Community Hospital
- May 3 Effingham—St. Anthony Memorial Hosp.
- May 4 Division Cardiac—U. of I. at the Med. Center
- May 7 Peoria Cardiac—St. Francis Hospital
- May 8 Peoria General—St. Francis Hospital
- May 9 Chicago Heights Gen.—St. James Hosp.
- May 9 Joliet—St. Joseph's Hospital
- May 9 Champaign-Urbana—McKinley Hosp.
- May 10 Springfield General—St. John's Hosp.
- May 10 Macomb—McDonough District Hospital
- May 11 Chicago Heights Cardiac—St. James Hosp.
- May 15 Belleville—St. Elizabeth's Hospital
- May 15 Decatur—Decatur Memorial Hospital
- May 15 Rock Island General—Moline Public Hosp.
- May 15 Anna—Union County Hospital
- May 16 Evergreen Pk.—Little Company of Mary Hosp.
- May 16 Springfield Ped-Neuro—St. John's Hosp.
- May 16 Centralia—St. Mary's Hospital
- May 17 Elmhurst Cardiac—Mem. Hosp. of DuPage Co.
- May 17 Rockford—Rockford Memorial Hospital
- May 18 Kankakee Cardiac—St. Mary's Hospital
- May 21 Maywood—Loyola Medical Center
- May 21 Peoria Cardiac—St. Francis Hospital
- May 22 Alton—Alton Memorial Hospital
- May 22 Danville—Lake View Hospital
- May 22 Peoria General—St. Francis Hospital
- May 23 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- May 23 Chicago Heights General—St. James Hosp.
- May 23 Elgin—Sherman Hospital
- May 25 Chicago Heights Cardiac—St. James Hosp.
- May 29 East St. Louis—Christian Welfare Hosp.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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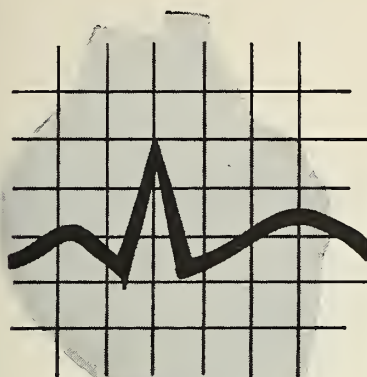
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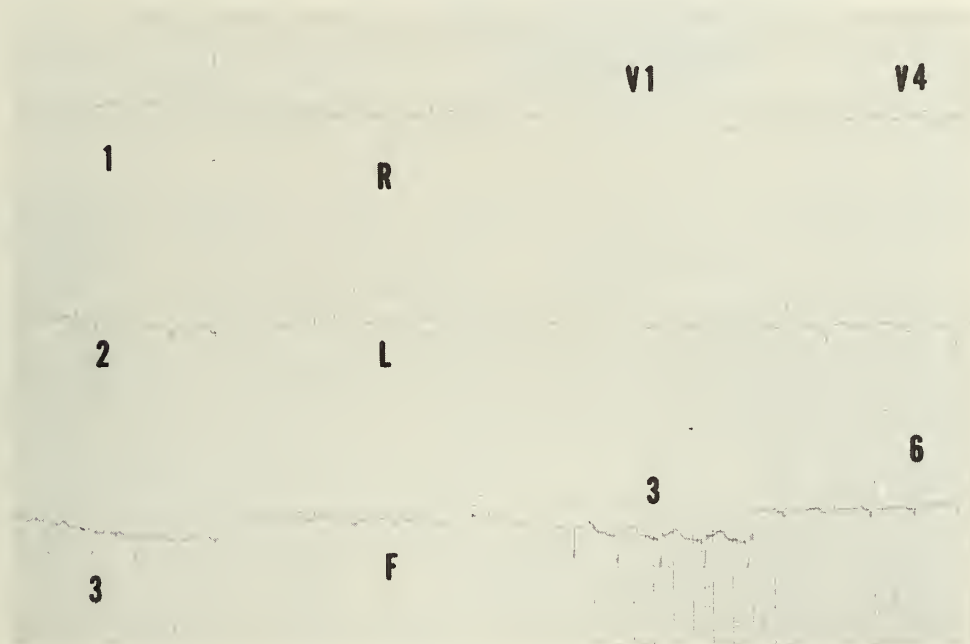
Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
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JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a 52-year-old man who presented to the emergency room with a two hour history of retrosternal chest pain that radiated to both arms. He had had shorter episodes in the week prior to his visit to the emergency room but blamed them on overwork. He had a positive cigarette smoking history of one to two packages per day for twenty-five years. Physical examination demonstrated a blood pressure of 90/60 mm Hg, a pulse rate of 140 beats/minute, bilateral basilar crepitant rales on examination of the lungs, and a loud atrial gallop on examination of the heart. No heart murmurs or pericardial friction rubs were heard. This 12 lead ECG was taken.



Questions:

1. The ECG shows:

- A. Sinus tachycardia.
- B. Atrial flutter.
- C. Acute anterior wall myocardial infarction.
- D. Left ventricular hypertrophy.
- E. Right ventricular hypertrophy.

2. The following statement(s) is/are true:

- A. The patient should be admitted to the coronary care unit.

nary care unit.

- B. This patient is a candidate for hemodynamic monitoring at the bedside.
- C. This patient could be a candidate for the clinical syndrome of cardiogenic shock.
- D. Cardiac arrhythmias such as ventricular tachycardia might be expected here.
- E. All of the above.

(Continued on page 276)



Salary and Benefits Survey

By LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

The RPS governing council has completed a poll of Illinois hospitals about their salary structures and benefits for residents. It is hoped that these figures may be some use to residents in negotiating their contracts as well as to medical students assessing potential residency programs. Salary and benefits are rarely an issue in choosing a residency, since most prospective residents focus mainly on the medical aspects of programs they consider. Once on the job, however, fine points of health care services available or laundry or meals can assume a great deal of importance. 30 hospitals responded.

Average salaries were as follows: PGI: \$14,421; PGII: \$15,311; PGIII: \$16,271; PGIV: \$16,432; PGV: \$18,097; PGVI: \$18,960.

The following benefits were noted:

Miscellaneous	Yes	Partially	No	"Moonlighting"		
Meals provided	7	13	10	Permitted out of institution	16	1
Laundry of coats	12	7	10	Available within institution	15	14
Parking provided	22	3	5			
Pay for excess call	3	—	24	Housestaff Association	12	17
Photo copying privileges	22	—	8	Contract participation	8	17
Free prescriptions	7	7	14			
Conference travel reimbursement	20	6	4			
Insurance				Other benefits mentioned by some hospitals:		
Major Medical	28		2	Dues paid for ISMS, AMA and AAFP		
Disability	18		10	Free lab service for resident and family		
Malpractice	27		3	Sick leave—one institution offers ten sick days, two		
Dental	8		18	personal days, three funeral days, and		
Life	24		4	interview days.		
Retirement	6		20	Housing subsidies or low-cost housing.		

The response made it clear that a wide range of salaries and benefits are offered in the state of Illinois. A somewhat similar but lengthier survey is conducted yearly by the Chicago Hospital Council. This volume, entitled, "Stipend Survey of Residents and Housestaff Physicians for Chicago Area Hospitals," is distributed to most Graduate Medical Education directors.

Copies of the RPS Housestaff Survey may be obtained by writing to the ISMS-RPS at 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

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DOWNSTATE MEDICARE PART B WORKSHOP SCHEDULE

Registration 1:00 p.m.-1:30 p.m. — Meeting 1:30 p.m.-3:30 p.m.

Date	Location	City	Street Address
May 30	Moline Public Hospital	Moline, IL	635 10th Avenue
June 6	Holiday Inn	Glen Ellyn	1250 Roosevelt Rd.
June 7	Sheraton Motor Inn	Waukegan	200 N. Greenbay Rd.
June 12	Ramada Inn	Peoria	415 St. Mark Ct.
June 13	Holiday Inn	Glen Ellyn	1250 Roosevelt Rd.
June 14	Holiday Inn	Joliet	19747 Frontage & I-55
June 19	Ramada Inn	St. Charles	1600 E. Main
June 20	Clock Tower	Rockford	7901 E. State
June 26	Augustine's	Belleville	1200 Centerville
June 26	Holiday Inn	Mt. Vernon	I-57 at US 15
June 27	Sheraton Motor Inn	Springfield	3090 Stevenson Drive
June 28	Ramada Inn	Champaign	1501 S. Neil

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Obituaries

***Alpert, Sidney**, Skokie, died January 9, 1979, at the age of 63. Dr. Alpert was a 1943 graduate of Chicago Medical School.

****Balmer, Frederick Barnard**, Maywood, died January 19, 1979, at the age of 87. Dr. Balmer was a 1916 graduate of Chicago College of Medicine and Surgery.

***Barone, Anthony M.**, Northfield, died October 19, 1978, at the age of 76. Dr. Barone was a 1929 University of Illinois graduate.

***Barron, David B.**, Skokie, died January 20, 1979, at the age of 57. Dr. Barron was a 1946 graduate of the University of Minnesota. He had served on the staff of Forrest Hospital.

***Brooks, Ernest R.**, Lombard, died February 15, 1979, at the age of 54. Dr. Brooks was a 1949 graduate of the University of Illinois and served on the staff of Westlake Hospital.

***Bunata, Emil J.**, Riverside, died January 15, 1979, at the age of 72. Dr. Bunata was a 1932 graduate of Northwestern University Medical School.

****Culpepper, William L.**, Shreveport, La., formerly of Pickneyville, IL, died November 24, 1978, at the age of 90. Dr. Culpepper was a 1915 graduate of Tulane University.

***Durham, William R.**, Harrisburg, died January 31, 1979, at the age of 48. Dr. Durham was a 1957 University of Illinois graduate.

***Ersfeld, John G.**, Chicago, died January 27, 1979, at the age of 63. Dr. Ersfeld was a 1941 University of Illinois graduate.

***Fox, Sherwin A.**, Chicago, died February 21, 1979, at the age of 48. Dr. Fox was a 1956 University of Illinois graduate. Chief of the ophthalmology department at Illinois Masonic Medical Center, he had served on the staff of Skokie Valley Community Hospital.

***Gordon, Robert P., Jr.**, Oak Brook, died January 10, 1979, at the age of 46. Dr. Gordon was a 1958 graduate of Northwestern University Medical School.

***Hill, Vincent R.**, Clearwater, Florida, formerly of Springfield, died in January 1979 at the age of 66. Dr. Hill was a 1944 graduate of the University of Illinois. He had served on the staff of St. John's Hospital and Memorial Medical Center in Springfield.

***Jenkins, Alexander**, Evergreen Park, died January 17, 1979, at the age of 72. Dr. Jenkins was a 1939 graduate of the Loyola University Stritch School of Medicine.

****Jenkinson, David Lester**, Lebanon, Indiana, formerly of Chicago, died January 21, 1979, at the age of 77. Dr. Jenkinson was a 1929 graduate of Northwestern University Medical School.

***Kessler, Donald L.**, Glenview, died February 15, 1979, at the age of 61. Dr. Kessler was a 1944 graduate of Northwestern University Medical School. He also was on the staff of the Evanston Hospital.

***Luzzie, Harry Lewis**, Chicago, died February 21, 1979, at the age of 66. Dr. Luzzie was a 1944 graduate of Chicago Medical School.

***Meyer, Harold I.**, Chicago, died January 21, 1979, at the age of 82. Dr. Meyer was a 1923 graduate of Rush Medical College. Senior attending surgeon at Rush-

Presbyterian St. Luke's Medical Center, he was also on the staffs of Cook County and Children's Memorial Hospital.

***Necheles, John**, Chicago, died January 31, 1979, at the age of 83. Dr. Necheles was a 1920 graduate of the University of Hamburg, Hamburg, Germany.

***Pagano, Alfred Louis**, Chicago, died January 30, 1979, at the age of 69. Dr. Pagano was a 1935 graduate of Chicago Medical School.

***Rosenberg, Charles Jacob**, Norris City, died August 28, 1978, at the age of 68.

***Schroeder, George F.**, River Forest, died February 16, 1979, at the age of 67. Dr. Schroeder was a 1937 graduate of the University of Wisconsin. He also was on the staff of Lutheran Deaconess Hospital.

****Sokolowski, Daniel T.**, Chicago, died February 2, 1979, at the age of 80. Dr. Sokolowski was a 1927 graduate of Chicago Medical School.

***Stagman, Joseph**, Chicago, died January 17, 1979, at the age of 69. Dr. Stagman was a 1933 graduate of the University of Illinois Medical School. He had also served on the staff of Michael Reese Hospital.

***Steinle, Aida S.**, Evanston, died February 11, 1979, at the age of 73. Dr. Steinle was a 1933 graduate of Loyola University Stritch School of Medicine and had served on the staff of St. Elizabeth Hospital.

***Wolski, Martin C.**, Rock Island, died January 29, 1979, at the age of 68. Dr. Wolski was a 1938 graduate of the University of Bratislava, Czechoslovakia.

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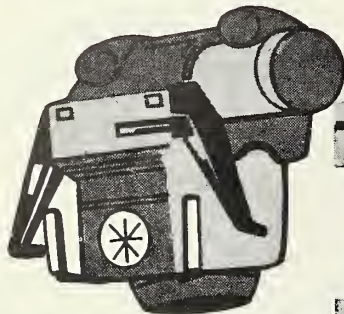
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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
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This month's Viewbox was contributed by Terrence C. Demos, M.D., clinical assistant professor of radiology, Loyola University Stritch School of Medicine.

This 42-year-old woman has urinary incontinence. This IVP (Figure 1) and bladder close-up (Figure 2) were obtained.

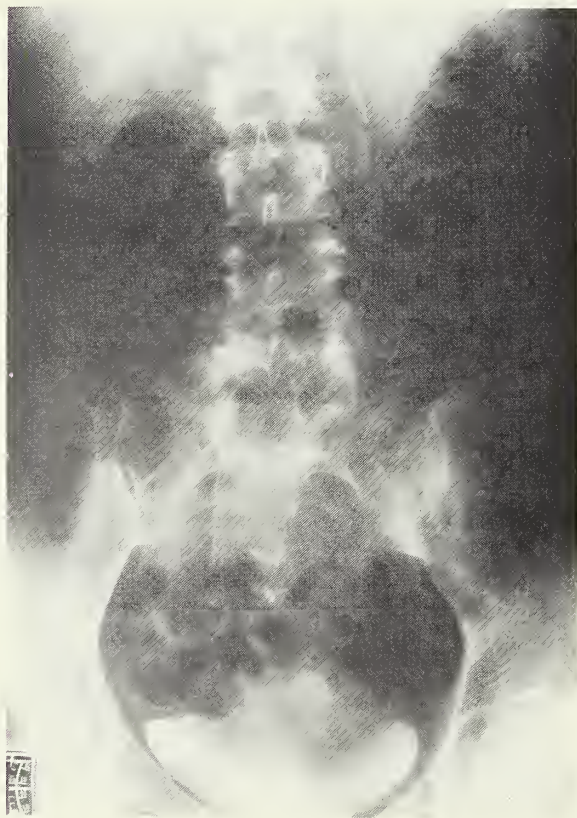


Figure 1



Figure 2

What's Your Diagnosis?

1. Urachal cyst
2. Bladder diverticulum
3. Vesicovaginal fistula
4. Cavitary neoplasm

(Continued on page 270)



I M J

Illinois Medical Journal

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Rehabilitation Difficulties

The Patient With Myocardial Infarction

BY PAUL E. KAPLAN, M.D., F.A.C.P./CHICAGO

Exercise in the rehabilitation of patients with coronary artery disease must be part of a comprehensive effort that is closely monitored to observe the effect upon coronary flow. The rehabilitative effort must consider the influence of contributing factors. Therapy should be initiated on a group basis to address vocational, social, and psychological stress.

Rehabilitation programs for myocardial infarction patients have depended upon regular exercise in community facilities. Several studies have detailed the beneficial effects of physical conditioning.¹⁻³ Blood-pressure and heart rate decrease while stroke volume increases after regular exercise.⁴⁻⁷ As a result, cardiac work and the oxygen demand were reduced during the exercise program but greatly increased over resting conditions.

It appears that the overall reasoning for increased exercise was that cardiac muscle would adjust itself to increased demand by becoming more efficient. The normal heart would respond by dilating coronary vessels, reducing the amount

of increased oxygen consumption, and, in time, reducing the added cardiac work.

Were the coronary arteries of atherosclerotic patients that compliant? A decreased myocardial contractility due to inadequate oxygen supplies was produced in patients with marked cardiac disease performing strenuous exercise.⁸ Reduction of the rate of myocardial fiber shortening has been documented in patients with heart disease as compared to the increased rate noted in a control group.⁹ The left ventricular contractility of the cardiac group was reduced prior to exercise. In addition, increasing work capacity has not been correlated with changes in ST segment depression.¹⁰ On the other hand, work capacity and stroke volume have improved in patients with myocardial infarction after training periods.¹¹ As a result, it was not clear that the atherosclerotic heart became more efficient with exercise.

While collateral circulation may develop after an infarction, no clear correlation has been noted between the increase in physical exercise and the development of anastomotic channels. The one animal study supporting this correlation¹² has not been confirmed.¹³ Indeed, studies on exercise and cardiac disease, including repetitive



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coronary angiography, failed to show any significant effect of exercise on angiography.^{6,14} Was increased exercise capacity associated with secondary anastomotic circulation formation?

Areas For Further Study

Controlled studies are needed. Within functional classes I & II (N.Y. Heart Assn.) there is a wide latitude in patient selection.¹⁵ Moreover, the patient is literally plugged into a system. If the program has a supervisor present, the patient may obtain personal care and advice and may even release his competitive urges through exercise. Studies suggest benefits of group psychotherapy in treating patients with coronary disease.¹⁶ How can the psychologic benefits of the exercise program be evaluated apart from the physical sequelae? In a study with random controls, exercised patients showed a significant reduction in total deaths and in cardiac deaths. However, 25% of the control groups were excluded from convalescent exercise.¹⁷

Exercise has resulted in cardiac arrest and death.^{18,19} The impact of driving and of sex in relation to various diseases have been areas of study.²⁰⁻²² Limitation of excessive physical activity might help prevent cardiac arrest. A good safeguard would have been monitoring the effect of exercise on coronary perfusion, for example, the use of noninvasive radioisotope techniques to observe coronary artery flow.²³

Many factors influence the development of coronary disease. Metabolic studies have identified patients with atherosclerotic heart disease and hyperlipoproteinemia.^{24,25} Atherosclerosis has been linked to proliferations of smooth muscle cells in the intima of arterioles and to the incidence of various neoplasms.^{27,28} Cholesterol metabolism would thus be associated with the production of substances augmenting growth of smooth muscle cells. Nutritional alterations might reverse these effects. Drugs lowering lipid levels have been valuable additions to the rehabilitation regimen of these patients.²⁹ Platelet aggregation has also been important. The combination of stroke and heart disease is not uncommon.³⁰ Increased platelet aggregation in a younger patient has been related to thrombotic disease.³¹ The response of platelet aggregation to treatment has been observed.³² All of the factors associated with the course of coronary disease must be considered.

Angiographic studies in patients with angina pectoris on an exercise program have demonstrated that some coronary arteries that are

stenosed may slowly occlude.³³ Collateral circulation developed with total occlusion of the stenosed artery. Would a patient with atherosclerotic coronary vessels after exercise have an augmented exercise tolerance due to a silent myocardial infarction? Would this situation then represent an advance in rehabilitation? In addition, the influence of genetic factors determining the development of collateral circulation has been emphasized.³⁴

Physical conditioning alone is probably not the solution to the problems presented by cardiac rehabilitation. Group therapy treatment of vocational, socioeconomic, and psychological stress may be a very effective method in cardiac rehabilitation.¹⁶ Effective allocation of available energy should be emphasized. The quality of life should be improved without decreasing the cardiac reserve. ◀

References

A complete list of references for "Rehabilitation Difficulties: The Patient With Myocardial Infarction," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Evaluation of Treatment with Respect to Radiotherapy

Carcinoma Of The Oesophagus

BY WAGIH M. SHEHATA, M.D., F.F.R./CINCINNATI, OHIO

The extremely low survival rate of carcinoma of the esophagus stimulated us to review the role of radiotherapy in the management of 30 patients. Only two survived free of disease for three and five years. Excellent palliation of dysphagia could be achieved in two-thirds of the cases and partial relief in the remainder. Twelve cases had recurrence of dysphagia (six had received only palliative doses) but were usually associated with extensive disease before death occurred.

The role of surgery (curative and palliative) and chemotherapy is carefully discussed as compared to radiotherapy.

Carcinoma of the esophagus represents one of the most fatal cancers regardless of its site, histology or mode of therapy.^{1,2} In spite of a reliable, easy diagnosis by simple barium swallow,³ the majority of patients are discovered with advanced disease beyond cure. This is related to submucosal extension of the disease, lack of serosa in the esophagus,⁴ peristaltic movements,⁵ and frequent nodal metastases.⁴ Nicks¹ documented 305 out of 332 patients showing complete penetration of the wall of the esophagus with lymphatic glandular involvement.

The overall five year survival rate ranges from 3-8% regardless of the mode of therapy.^{1,4,6,7} Out of resected cases, less than 10% are cured by surgery alone,⁶ with an average resectability rate of 23%.⁸ Radiotherapy proved to be effective as a preoperative modality and improved survival.^{1,6,9,10-12} It is also reasonably effective for palliation^{7,13} but the cure rate is not encouraging.¹⁴ The fact that only about 20% survive beyond one year¹³ by any modality dictates that mortality and morbidity from therapy should be kept minimum. Most of the patients need palliation for the distressing symptoms of dysphagia.¹⁴ It is mandatory to help those starving patients who are choking on their own saliva³ (normal-

ly about 2500 ml. per day).

Chemotherapy^{3,15,16} so far seems to have little or no effect. Quite often patients are not fit for chemotherapy due to associated poor general conditions and elderly age.³

The aim of this study is to evaluate a total of 30 patients treated by radiotherapy at the Hinsdale Sanitarium and Hospital, Hinsdale, IL, from 1970 to 1975, and to discuss other modalities of therapy as compared to that mode of treatment.

Materials and Methods

Twenty-six patients were males and four were females with a median age of 65 (youngest 49 years male, oldest 89 years male). All patients except one (black) were white. All were moderate to heavy smokers and 80% had a history of alcohol consumption. All had squamous cell carcinomas except two adenocarcinomas involving the lower third of the esophagus who were treated only for palliation. In eight patients the tumor involved the upper third of the esophagus, fourteen patients the middle, and eight patients the lower third of the esophagus. The American Joint Committee for Cancer Staging (AJCCS) system was adopted.⁴ Four patients were classified as Stage I, twelve Stage II and fourteen Stage III. The average length of the lesion radiologically was 6 cm. A total of 14 patients were treated by radiotherapy for palliation to the primary (eight with nodal metastases in the neck or celiac area, four with bony metastases and two patients with local extensive disease). Those patients received 1200, 1600 ret. (equivalent to about 4,000-6,000 rads in 4-6 weeks). The remaining 16 patients were treated by radiotherapy with a cura-

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tive intent receiving doses of 5,000-6,500 rads. The technique involved treating most of the esophagus by super voltage therapy (Cobalt 60), utilizing two parallel opposing anterior and posterior fields for a dose of 3,000 to 4,000 rads in three to four weeks. In cases treated for cure radiotherapy continued by reduced ports utilizing multiple fields or rotational therapy arc for a total tumor dose of 6,000 to 6,500 rads in six to seven weeks.⁴ Upper third lesions were usually treated by two antero-lateral wedged fields.¹³ Split course technique was used if the patient's condition indicated. Two cases received a preoperative radiotherapy for 4,000 rads in four weeks followed by resection and survived four and six months after surgery; the first patient died as a result of surgical complications.

It was our policy not to treat any patient with a broncho-esophageal fistula by radiation since the fistula does not heal after radiation therapy. None of our patients developed any fistulas as a result of radiotherapy.

Ten patients had prior gastrostomies for feeding prior to radiotherapy. In six patients the gastrostomy was closed three to six months after therapy due to improvement of dysphagia and upon request by the patient. Two of those six patients developed recurrence of dysphagia shortly before death and also had local and distant metastases. Careful search for nodal disease in the neck and distant metastases (especially liver) helped to select cases for palliation versus cure by radiotherapy. Four patients had prior laparotomy and gastrostomy as a part of surgical evaluation. None of our cases had received chemotherapy.

Results

All cases presented initially with various degrees of dysphagia. Twenty (66%) patients had excellent palliation of dysphagia (fourteen of whom received curative doses) and could again eat solid foods. In the other ten patients (33%) (six of whom received palliative doses) partial relief of obstruction was obtained. They could be managed with soft foods. Improvement in dysphagia was sustained until death except in 12 cases (six received only palliative doses) with probable persistent or recurrent disease (four of whom had gastrostomy). In those twelve patients dysphagia developed shortly before death and was associated with distant metastasis (probably failed locally and generally). This possibly could be due to reseeded in the treated area rather than treatment failure. None of the patients de-

veloped serious morbidity including stricture or spinal cord myelitis. All patients are dead except one living with disease two years after therapy and two patients free of symptoms and disease for three and five years after radiotherapy respectively. One of two long survivors had carcinoma in the upper third and the other patient at the junction of the upper and middle thirds (Stage I and II). The median survival for all patients was 11.4 months. Twelve of 30 patients (40%) survived for one year and six out of 20 (33%) survived for two years. Distant metastases were documented in a total of fourteen patients (six to liver, four to bone, two to brain and two to the lymph glands of the neck). Four patients came to autopsy.

Discussion

Surgery: The five year survival with surgery alone is less than 10%⁶ with an overall resectability rate not better than 23%.^{6,8} The overall surgical mortality is 40%, 24% and 12% for tumors in the upper, middle and lower thirds respectively.^{4,14} Some surgeons even consider upper third lesions as contraindication to surgery due to the high rate of complications and mortality.^{14,17,18} The need for total esophagectomy^{13,19} is obvious since 45 to 80% spread to the margin of resection.¹⁹ This usually adds to the surgical difficulties of resection and reconstruction for patients who are usually elderly and poor risks medically. All these factors tend to diminish the role of surgery for cure of esophageal cancer, except possibly in adenocarcinoma of the lower third of the esophagus and cardia.²⁰ Tanner²¹ reported lower third lesions responding alone to radiation therapy. It seems advisable to perform laparotomy^{5,12} prior to definitive surgical treatments for evaluation of intra-abdominal spread. This is done quite often at the time of gastrostomy for feeding. Endoscopy and dilatation, although used frequently, usually does not provide satisfactory relief of symptoms for it carries the danger of perforation.¹⁴ For the same reason it should be used with caution for stricture cases following radical radiotherapy.

The case of palliative surgical resection is even more tenuous and probably unjustifiable. Other modalities, including radiotherapy, for example, are more effective and associated with less mortality and morbidity.^{16,20,22-24} Even simple palliative surgical procedures are associated with a relatively high rate of mortality and complications. Palva⁸ reported 16% primary mortality from insertion of celestine tube and 25% from gastros-

tomy. Although the passage of a tube might help relieve dysphagia^{8,22} it has the danger of perforation and could necessitate laparotomy for retrograde insertion.³ Palliation by a tube is not usually sustained beyond six months.⁸ Gastrostomy can correct dehydration and starvation but the patient is still unable to swallow his own saliva.⁸ Most patients consider it an artificial way of living since they don't enjoy the taste of food. In our series, the majority of the patients were able to swallow until shortly before death. Nakayama^{11,12} presented one of the best surgical results which is rather difficult to reproduce elsewhere with a 2,000 to 2,500 rads preoperative super voltage therapy in four to five days. Five year survival in 191 patients were 37.5% versus 19.1% for surgery alone. In his experience and in others, this did not increase mortality (6.2%) or morbidity.^{1,6,11,12} Lymph node metastasis, perforation or bleeding at surgery were also diminished with preoperative radiotherapy.^{11,12} Post-operative radiotherapy is not advisable in carcinoma of the esophagus due to the poor tolerance of the transplanted colon or small bowel to curative doses of radiation.⁴ Combination of radical surgery and radiation therapy could not be tolerated and is considered unjustifiable due to higher morbidity.²⁵

Curative Radiotherapy:²⁶⁻²⁹ Tanner and Smithers²¹ published results of 335 survivors with esophageal carcinoma. Of the upper two-thirds lesions, fifty-five patients survived after radiation therapy alone and forty-five after surgery. Later on, Pearson^{20,23,24} achieved about 20% five year survival after doses of 5,000 rads in four weeks.²⁶ The main disadvantages of radiation²⁷ were basically relatively long latent period until improvements, local recurrence rate of about 10% and 50% strictures in the cured cases. In our series excellent palliation of dysphagia was obtained in 66% of the cases with partial relief of the remainder. This is comparable to Lewinsky¹³ who showed 66% improvement of dysphagia, 80% improvement by esophagogram and 44% tumor sterilization at autopsy. It is important to carefully screen the patients for distant metastasis to avoid the possible risks of high dose radiotherapy. Every effort should be made to decrease the complications of radiotherapy by adequate planning for cases treated for cure.¹³ Our report of 40% and 33% survival for one and two years are better than in other series.^{13,21,26}

Recent reports utilizing a combination of neutron beam³⁰ and super voltage therapy seem encouraging for local control.

Chemotherapy has been used without significant gratifying results.^{3,16,31} Various drugs have been tried. For example, cyclophosphamide,^{32,33} Bleomycin,^{3,15,34,35} Methotrexate,¹⁶ CCNU,¹⁵ Mitomycin C,³⁶ Sarcosyl,³⁶ 5 fluorouracil,³⁶ and hydroxy urea.³⁷ None of the drugs used alone showed encouraging results (except 5 fluorouracil in adenocarcinoma of the lower third of the esophagus),³ while some improvements were reported in the adjuvant use of chemotherapy with radiation therapy.^{3,15,16,34,35,37,38}

Further efforts are needed for further trials of chemotherapy in combination with other therapeutic modalities³⁸ to improve the bleak outcome of this disease.

Conclusions

Radiation therapy is a satisfactory modality for palliation of esophageal carcinoma with no significant morbidity and practically no mortality. It could be curative in selective cases. ◀

References

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First Case In The Literature

Lymphomatoid Granulomatosis Presenting as an Abdominal Mass

DENNIS R. SAMUELSON, M.D., WERNER SCHOENHERR, M.D.,
CHARLES S. EDDINGFIELD, M.D./MACOMB AND CARTHAGE

The first case of an atypical lymphoreticular process presenting as an abdominal mass, consistent with the recently described entity of lymphomatoid granulomatosis is reported. This case further expands the diverse possible presentations of this infrequent entity and adds to the differential diagnostic considerations in patients with fever and an abdominal mass.

Lymphomatoid granulomatosis is a systemic disease first described by Liebow, Carrington and Friedman in 1972 that resembles malignant lymphoma and Wegener's granulomatosis.¹ It is characterized by predominant pulmonary involvement with frequent associated lesions found in the skin, central nervous system, kidneys, adrenals, paranasal sinuses, liver and spleen. Heart and lymph node involvement also has been noted.² The histologic hallmark characterized by Liebow is that of an angiocentric, angi-destructive lymphoreticular proliferative and granulomatous process with a variable clinical

natural history. The disease often exhibits a rapid and progressive course, but corticosteroid induced arrest has been recorded.³ This is generally a disorder of middle age with a slight preponderance in males.

The following case is to our knowledge the first reported example of lymphomatoid granulomatosis presenting primarily as a febrile disease with a palpable abdominal mass.

Case Report

A 58-year-old Caucasian female was admitted to the hospital with complaints of fever, weight loss,

night sweats and progressive malaise. Thorough clinical evaluations four months and six weeks prior to admission had been unrewarding.

She denied headache, abdominal pain, diarrhea and urinary tract symptoms and presented as a febrile, middle-aged, sick appearing female with an 8 cm. mid-abdominal mass located 3 cm. left of the umbilicus. This mass was nontender. Her bowel sounds were normoactive and her neurological exam was within normal limits. She did exhibit fine rales in both bases on auscultation and examination of the skin showed evidence of recent weight loss. There was no detectable hepatosplenomegaly.

An intravenous pyelogram was normal as was a barium enema. A chest X-ray exhibited a left perihilar infiltrate with nodular densities in the left base. There was no evidence of pleural fluid. Her body temperature was 101° on admission and her pulse was 88 and regular. Blood pressure was 126/82.

A CBC was 5,800 with a normal differential and the hemoglobin was 11.9 gms/dl. Platelets appeared adequate on peripheral smear and a urinalysis was normal. The LDH was 424 mU/ml. (normal 100-225 mU/ml) and the alkaline phosphatase was 152 mU/ml. (normal 30-115 mU/ml.). An amylase was 103 dye units/dl. (normal 60-200 dye units/dl.) and the erythrocyte

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sedimentation rate was 40 mm./hr. (normal less than 20 mm./hr.). Plasma pH was 7.4, sodium 135 mEq/L., potassium 4.2 mEq/L., chloride 106 mEq/L. and CO₂ content 26 mM/L. Three blood cultures were obtained shortly after admission, however there was no growth at 48 hours. Febrile agglutinins were negative.

During the ensuing week the patient's temperature spiked every evening to levels between 101° and 105°F. She was maintained on a general diet with diazepam and aspirin p.r.n.

Her electrocardiogram was normal and triglycerides were 95 mgs/dl. on the second hospital day. A repeat chest X-ray on the eighth hospital day exhibited a distinct increase in patchy infiltrates in both lung fields. An elective laparotomy was performed and a large, partly necrotic, 10 cm. retroperitoneal mass was noted at the root of the small bowel mesentery. This appeared to extend caudally to near the pelvic brim. The liver and spleen were grossly minimally enlarged.

Blood cultures remained negative and on her eleventh hospital day she was extremely dyspneic. An arterial PO₂ was 33 mm. Hg., PCO₂ was 35 mm. Hg. and pH was 7.50. She received three units of packed red cells postoperatively and on the twelfth hospital day repeat chest film exhibited further increase in the nodular pulmonary

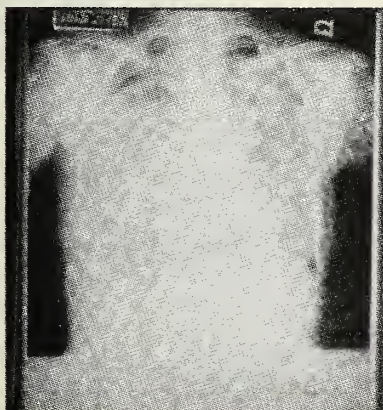


Figure 1
Chest X-rays, Pre-thoracotomy.



Figure 2
Photomicrograph of a non-necrotizing nodular lung lesion.

infiltrates (Figure 1). In view of her progressive deterioration, a diagnostic right anterior thoracotomy was performed with biopsy of several nodular densities subpleurally adjacent to the pericardial sac and in the right middle lobe.

The patient had empirically received ampicillin, 4 gms. q.d., and was subsequently started on hydrocortisone, 250 mgs., intravenously q. 6 h. She promptly became afebrile and her medication was changed to 15 mgs. of Prednisone q.i.d. On the eighteenth hospital day she again exhibited a temperature rise to 101°F. Despite increasing corticosteroid therapy the patient continued to manifest daily temperature elevations with increasing dyspnea. She expired on the twenty-first hospital day.

Post Mortem Findings

At necropsy an extensive suppurative peritonitis with associated right subphrenic and pelvic abscesses was noted. This terminal sepsis is assumed to be related to the predisposing immune alteration attributable to pharmacologic steroid therapy as well as the necrotizing retroperitoneal process with recent abdominal surgery.

The granulomatous lymphoreticular lesions were found to involve both lungs extensively with nodules up to 2.5 cm. in diameter (Figure 2). The right middle and upper lobe displayed numerous nodules as did the lingular portion of the left upper lobe and the left lower lobe. Many of these displayed necrotic centers margined by a

dense polymorphic cellular infiltrate consisting of principally lymphocytes with large atypical mononuclear cells, interspersed plasma cells, and rare eosinophils. The outstanding distribution feature of the infiltrate was the angiocentric nature with full thickness invasion of both arteries and veins (Figure 3).

The retroperitoneal mass was 12 cm. x 8 cm. and involved the root of the small bowel mesentery with extension to the pancreatic head and resultant displacement of the distal duodenum to the right and rostrally. This mass on section displayed interspersed foci of fat necrosis with supporting fibrous induration and admixed focally necrotic lymph nodes ranging from 1 to 3 cm. in diameter. The polymorphous atypical infiltrate also involved the adventitia of the fourth portion of the duodenum. Hepatic portal triads focally displayed lymphoreticular infiltrates similar to the infiltrate in the pulmonary nodules and retroperitoneal mass, however this was largely confined to the portal and periportal areas without significant architectural effacement. The histology of the retroperitoneal involvement was likewise that of a necrotizing atypical lymphoreticular granulomatous process which was distinctly angiocentric and angiodestructive. Routine acid fast and fungus stains were negative. The necropsy examination was limited to the thorax, neck and abdomen.

Discussion

An abdominal form of lymphomatoid granulomatosis with distinct pulmonary sparing has been recently described by Chen.⁴ This author, however, noted primary hepatomegaly and splenomegaly with clinically nonpalpable nodular disease in the mesentery and retroperitoneal lymph nodes. Yockey, *et al.*, also recorded a case of predominantly abdominal lymphomatoid granulomatosis in a 26 year old male with associated fever and delayed appearance of lung and central nervous system involvement.² The present case serves to further illustrate the polymorphic

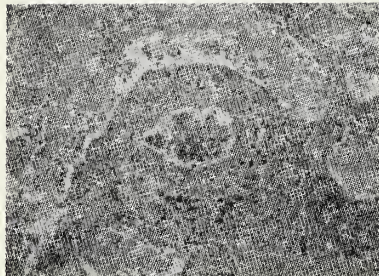


Figure 3
Photomicrograph of a cross-sectioned artery with angiocentric infiltrate.

character of lymphomatoid granulomatosis, more specifically of the abdominal form. The mode of presentation is also somewhat more dramatic than the heretofore described abdominal forms with a distinct clinically palpable, mid-abdominal mass. This description also serves to add to the existing lengthy list of differential diagnoses in abdominal masses as well as,

possibly, fever of unknown origin.

The differential diagnoses in this case included the limited form of Wegener's granulomatosis, however, the extensive cellular infiltrate and prominent histologic atypicality are more characteristic of lymphomatoid granulomatosis. Lymphoma, especially Hodgkin's disease, was also a distinct consideration although the striking angiocentric nature of the infiltrate, absence of unequivocal Reed-Sternberg cells, and sparing of hilar and paratracheal lymph nodes served to exclude this diagnosis.

The etiology of lymphomatoid granulomatosis remains speculative, although the close resemblance morphologically to Wegener's granulomatosis has suggested to some that this may represent a variant in the spectra of this process. Previously reported termination of lymphomatoid granulomatosis in malignant lymphoma also raises the question of the relationship to malignant lymphoproliferative dis-

eases.¹

The histologic material from this case was reviewed by the Armed Forces Institute of Pathology, Washington, D.C. ◀

References

1. Liebow, A. A., Carrington, C. R., Friedman, P. J.: "Lymphomatoid Granulomatosis," *Human Pathology*, 3:457-558, 1972.
2. Yockey, C. C., Leichter, S. B., Hampton, J. R.: "Lymphomatoid Granulomatosis Presenting as Fever of Unknown Origin," *JAMA*, 237:2633-2634, 1977.
3. Lee, S. C., Roth, L. M., and Brashear, R. E.: "Lymphomatoid Granulomatosis: A Clinical Pathologic Study of Four Cases," *Cancer*, 38:846-853, 1976.
4. Chen, K. T. K.: "Abdominal Form of Lymphomatoid Granulomatosis," *Human Pathology*, 8:99-103, 1977.

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Malignant Schwannoma of the Brachial Plexus

ROBERT R. RICHARDSON, M.D., SHIZUO OI, M.D., EDIR B. SIQUEIRA, M.D., PH.D.,
AND CARLOS NUNEZ, M.D./CHICAGO

Schwannomas of the brachial plexus are very rare clinical entities.¹⁻⁵ Only two case reports could be found over the past 25 years.^{1,4,5} A malignant schwannoma of the brachial plexus, which occurred unassociated with von Recklinghausen's disease, is even rarer.^{1-3,5} The clinical presentation of schwannomas of the lateral cervical region, which includes the brachial plexus, is that of a mass lesion with its associated complications, mainly localized or radicular pain.^{1-3,5} Recently we treated a patient having the diagnosis of malignant schwannoma of the brachial plexus.

While benign solitary neurogenous tumors and neurogenous sarcomas are most commonly found in the lateral region of the neck, solitary malignant schwannomas of the brachial plexus are rare, especially if they are *unassociated* with von Recklinghausen's neurofibromato-

sis. We are reporting a case of malignant schwannoma of the brachial plexus that posed clinically diagnostic and surgically therapeutic problems. Malignant schwannomas present initially as visible, tender, or palpable masses, frequently associated with pain or

weakness along the distribution of the involved peripheral nerve. Motor signs produced by these tumors involving the brachial plexus usually indicate a malignant lesion and a poor prognosis. While wide radical excision of these malignant tumors is surgically indicated, our patient had an early malignant recurrence that necessitated amputation.

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CARLOS NUNEZ, M.D., is a fellow in the department of pathology at Northwestern Memorial Hospital in Chicago. The former chief resident in pathology at Northwestern, Doctor Nunez is particularly interested in electron microscopy applied to surgical pathology and related ultrastructural studies.

Case Report

This 26-year-old white female had been hospitalized several times at Northwestern Memorial Hospital for evaluation and treatment of pain over the right arm associated with weakness of the right biceps. Electromyographic studies showed fibrillations and positive spike waves over the right biceps. The patient had an exploration of the right brachial plexus in July of 1975. At operation a large tumor arising from the right musculocutaneous nerve was found and excised (Figures 1 and 2). Microscopic examination showed findings consistent with a diagnosis of ma-

Figure 1
Microscopic section showing densely cellular, moderately pleomorphic bundles alternating with sparse cellular foci, suggesting Antoni A and B areas (following second operation).

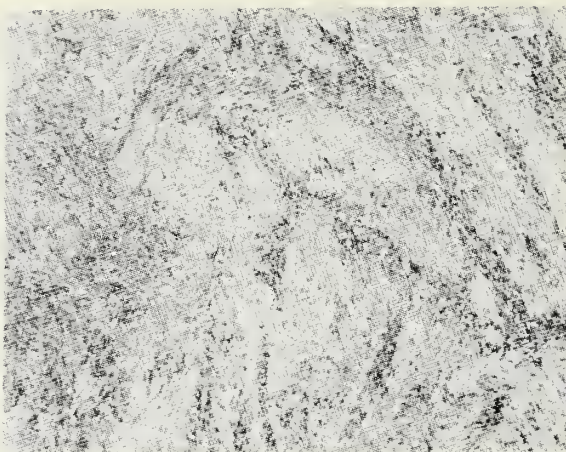
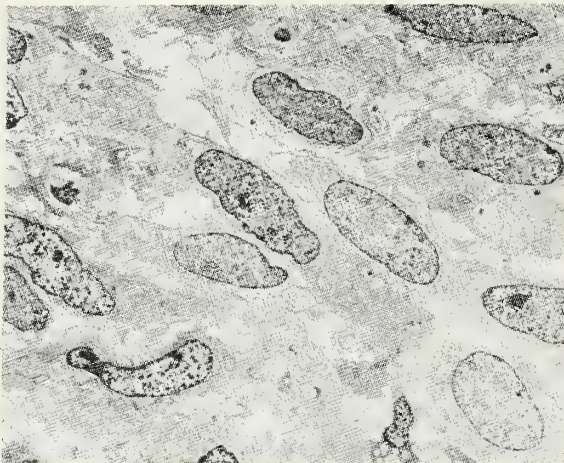


Figure 2
Spindle cells in electron micrograph often show long slender projections closely contacting each other. Rare intercellular junctions are present. Electron-dense amorphous material is often closely apposed to the cellular membranes, but a definite basal lamina is not identified.



lignant schwannoma. She received palliative radiation therapy. The involved extremity was not amputated because of her age.

In early June of 1976, patient noticed a mass at the level of the previous incision. She also noted increasing "numbness" of the first, second, and third digits of the right hand and was unable to flex them. On examination the patient was found to have a hard mass in the right supraclavicular region. Patient reported radiation of pain into the right elbow when the mass was palpated.

The patient underwent a biopsy of this mass which proved to be a recurrent tumor. One week later, a four quarter amputation of the right shoulder was performed.

Pathological Findings and Methods

The cut surface of the mass lesion showed firm white tissue with multiple areas of gelatinous, hemorrhagic, and soft yellowish tissue (Figure 3). Malignant schwannoma was the pathological diagnosis of the tumors from both operations (Figures 1 and 2).

Tissues for light microscopic and electron microscopic examinations were fixed, stained, sectioned, and studied in the appropriate manner.⁶

Discussion

The solitary, benign peripheral nerve schwannoma is *almost never* associated with von Recklinghausen's neurofibromatosis or a malig-

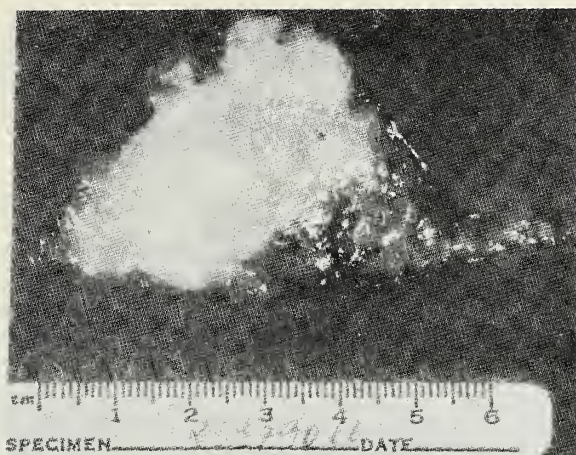
nant transformation.^{1-3,5} While a schwannoma is the most common tumor found in the lateral cervical region,^{1,2,4} benign and malignant schwannomas of the brachial plexus have only occasionally been reported.¹⁻⁵ Most cases of malignant schwannoma occur in early or middle adult life (20 to 50 years), and no sex preference is apparent.

The most common initial manifestation of a schwannoma of the lateral cervical region is that of a visible or palpable mass.¹⁻⁵ Frequently there is localized pain and occasionally associated radicular pain along the involved peripheral nerve.¹⁻³ Sensory symptoms or motor paralysis of the affected nerve trunk usually occur late.^{1,2,8} However, objective findings of sensory or motor loss early indicate clinically the presence of a malignant lesion.^{1-3,8} When loss of peripheral nerve function occurs in the developmental course of this tumor, there is discrepancy over whether the chief etiological factor responsible is segmental demyelination, pressure or loss of vascularity.

As the primary mode of therapy, Cutler and Das Gupta have found radiation therapy disappointing.^{2,7} The treatment of choice is surgical biopsy and extirpation.¹⁻³ If, at the time of the operation, the lesion is found malignant, wide radical resection is indicated. While chemotherapy has not been proven effective, palliative radiation may be beneficial.^{2,7} Since the patient developed a rapid recurrence, which was confirmed at a second operation, amputation of the involved extremity was necessitated. Das Gupta stated that the incidence of local recurrence of a malignant schwannoma is greater than 70%.⁷ Early amputation of the involved extremity is necessary before the occurrence of pulmonary or regional metastases.^{2,3,7,8}

Since there are histological and clinical difficulties in distinguishing between a solitary schwannoma and a solitary neurofibroma *unassociated* with von Recklinghausen's disease, Batsakis prefers the term "neurogenous tumor."¹ Fine electron microscopic studies or specific histochemical tests are necessary

Figure 3
Gross specimen
of malignant
schwannoma re-
sected at first op-
eration.



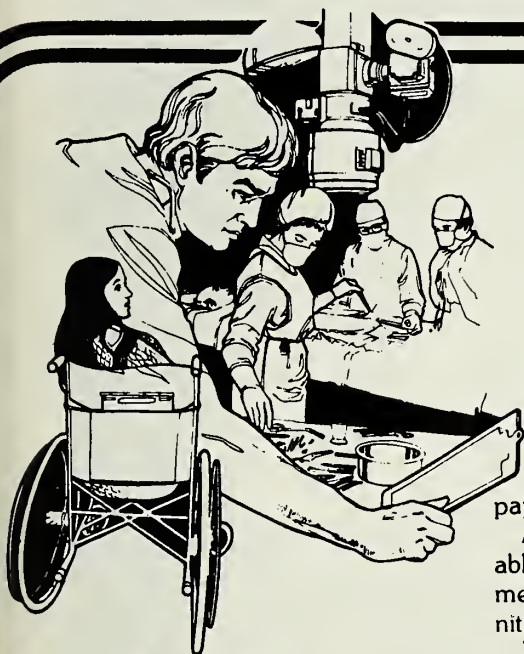
to differentiate between these solitary lesions whether benign or malignant (Figure 2).^{1,7}

In conclusion, a malignant schwannoma arising primarily from the musculocutaneous nerve of the brachial plexus *unassociated* with von Recklinghausen's neurofibromatosis is a rare clinical entity and requires aggressive surgical treat-

ment.

References

1. Batsakis, J. G.: *TUMORS OF HEAD AND NECK*. Chapter 16: Tumors of the Peripheral Nervous System, Baltimore, Williams and Wilkins Co., 231-240, 1974.
2. Cutler, E. C. and Gross, E.: "Neurofibroma and Neurofibrosarcoma of Peripheral Nerves Unas-
3. Ehrlich, H. E. and Martin, H.: "Schwannomas (Neurilemmomas) In the Head and Neck," *Surg. Gynec. Obstet.*, 76:577-583, 1943.
4. Helms, C.: "Massive Neurilemmoma of the Brachial Plexus," *Arch. Otolaryngol.*, 93:244-248, 1971.
5. Das Gupta, T. K., Brasfield, R. D., Strong, E. W. and Hajdu, S. I.: Benign Solitary Schwannomas (Neurilemmomas). *Cancer* 24: 355-366, 1969.
6. Navas, J. J. and Battifora, H.: "Primary Lymphoma of the Breast," *Cancer*, 39:2025-2032, 1977.
7. Rubinstein, L. J.: "Tumors of the Central Nervous System," pp 207-213, Washington, D.C., Armed Forces Institute of Pathology, 1972.
8. D'Agostino, A. N., Soule, G. H. and Miller, R. H.: "Sarcomas of the Peripheral Nerves and Somatic Soft Tissue Associated with Multiple Neurofibromatosis (von Recklinghausen's Disease)," *Cancer*, 16:1015-1027, 1963.



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Green, Martin W.	Harrod, John P., Jr.	Sinaiko, Edwin S.	Stopka, John E.
Guerrero, Severo K., Jr.	Head, Louis	Soboroff, Burton J.	Strohl, Lee H.
Hamilton, Robert C.	Henry, Harvey	Solon, Earl N.	Surath, Vasanth M.
Hinkamp, Joseph F.	Hollett, Alan M.	Sperling, Richard L.	Sutoris, Edward D.
Hoban, Eugene	Hussey, Frank L., Jr.	Springer, Harry	Swartz, Robert
Horton, Loren B.	Jaffe, Harry J.	Staley, Warren H.	Talso, Peter J.
Hrejsa, Allen C.	John, Thomas	Suckow, Earl E.	Tekdogan, Mehmet
Hutchison, William A.	Jones, Richard	Sugar, Sam J.	Thampy, Kishore J.
Hyde, John S.	Kass, Harold M.	Swartz, Robert M.	Tsatsos, George
Jacobs, W. Francis	Kerr, William D.	Tansey, William J.	Urban, Conrad J.
Jensen, Harold	Knudson, John A.	Thompson, J. Robert	Varzino, Louis
Jirka, Frank J., Jr.	Koch, Donald	Thrasher, Irving D.	Vega, Jesus
Joslyn, A. Everett, Jr.	Konecny, Philip	Tovar, Jorge	Yon, Mustafa
Kalsch, Harry E.	Landau, Richard L.	Treister, Michael R.	Zitek, Russell W.
Kaz, Alex H.	Lipsich, Michael	Turner, George C.	Zurita, Victor
Kirschenbaum, M. Barry	Lucina, Pedro A.	TwoRoger, Fred A.	
Kobak, Mathew	McCabe, Mary Joan	Ungar, Jacob	
Kowal, Roland A.	Meccia, Donald	Walkowiak, Lydia	
Kozak, John A.	Meyenberg, John	Wehrmacher, Wm. H.	
Kunis, Arthur	Mikhail, Kamel A.	Weigel, Charles J.	
Kwinn, Frank C.	Muehrcke, Robert C.	Weingarten, Charles Z.	
Lagorio, George L.	Murphy, Thomas E.	Williams, Jack	
Lobraico, Rocco V., Jr.	Murray, Meredith	Xydakis, Stephanos A.	

Officers of County Medical Societies

1979

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 105-Dist. 6 Maxine Boyer, Ex. Sec. 1 North State & Eighth Plaza Quincy 62301	A. J. Jumonville 1416 Maine, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
ALEXANDER Members: 6-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 10-Dist. 7	M. Kenneth Kaufmann 105 E. College, Greenville 62246	John K. Dawdy 404 Forest Lane, Greenville 62246
BOONE Members: 18-Dist. 12	James B. Ellis 119 S. State, Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
BUREAU Members: 36-Dist. 2	James Foresman 204 Park Ave. E., Princeton 61356	Donald M. Gallagher Box 538, Granville 61326
CARROLL Members: 8-Dist. 12	Eliseo M. Colli 102 E. Washington, Mt. Carroll 61053	Benjamin Sy Savanna Medical Center, Savanna 61074
CASS-BROWN Members: 2-Dist. 6		
CHAMPAIGN Members: 225-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Victor Feldman 104 W. Clark, Champaign 61820	H. Ewing Wachter 2108 W. Springfield, Champaign 61820
CHRISTIAN Members: 26-Dist. 7	Gloria Dycoco 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 5-Dist. 8	Howard G. Johnson Casey Medical Center, Casey 62420	Eugene P. Johnson P.O. Box 68, Casey 62420
CLAY Members: 7-Dist. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
CLINTON Members: 11-Dist. 7	Robert D. Roane 1131 Fairfax St., Carlyle 62231	James A. Kirby 401 N. Main, Breese 62230
COLES-CUMBERLAND Members: 45-Dist. 8	Anton Dippold 304 N. 22nd St., Mattoon 61938	Asit P. Basu 501 Jackson Ave., Charleston 61920
COOK Members: 8648-Dist. 3 Robert Lindley, Ex. Dir. 310 S. Michigan Ave. Chicago 60604	Clifton L. Reeder 734 N. Merrill, Park Ridge 60068	B. Franklin Lounsbury 927 Jackson, River Forest 60305
CRAWFORD Members: 15-Dist. 8	Thomas P. Sloan Schmidt Clinic, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DE KALB Members: 61-Dist. 12	Carroll F. Boyles 901 N. First St., DeKalb 60115	Loren W. Akers University Health Service Northern Ill. Univ., DeKalb 60115
DE WITT Members: 11-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
DOUGLAS Members: 8-Dist. 8	Walter Steiner 140 W. Sale Street, Tuscola 61953	Humberto Mondul 111 W. South Central, Tuscola 61953
DU PAGE Members: 616-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Ronald M. Severino 383 Schmale, Carol Stream 60187	James P. Campbell 322 N. Blanchard St., Wheaton 60187

COUNTY	PRESIDENT	SECRETARY
EDGAR Members: 16-Dist. 8	J. R. Shackelford 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
EFFINGHAM Members: 20-Dist. 7	Fabio H. Mota 300 N. Maple, Effingham 62401	Robert Farmer St. Anthony Memorial Hospital, Effingham 62401
FAYETTE Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
FORD Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 26-Dist. 9	James P. Durham Benton Med. Clinic, Benton 62812	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
FULTON Members: 37-Dist. 4	Rod Maguire 106 Martin, Canton 61520	Jai Cha 210 W. Walnut, Canton 61520
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 7-Dist. 6	Jude A. Caselton 9th St., Carrollton 62016	James C. Reid Fillager Mem. Clinic, Greenfield 62044
HANCOCK Members: 11-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	
HENRY-STARK Members: 38-Dist. 4	R. N. Svendsen 513 Elliott St., Kewanee 61443	Donald R. Ford 648 N. Chicago St., Geneseo 61254
IROQUOIS Members: 22-Dist. 11	Mohammed M. Razvi Rts. 1 & 24, Box V-347, Watseka 60970	G. P. H. De Vas Gunawardhane P.O. Box 638, Clifton 60972
JACKSON Members: 71-Dist. 9	W. J. Borgsmiller 215 N. 14th St., Murphysboro 62966	Antoinette G. Thomas 404 W. Main St., Carbondale 62901
JASPER Members: 2-Dist. 8	Don L. Hartrich 1211 W. Jourdan, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
JEFFERSON-HAMILTON Members: 33-Dist. 9	Kalangi T. Devaraj 140 E. Market, McLeansboro 62859	Kenneth A. Peart Doctors Park, Mt. Vernon 62864
JERSEY-CALHOUN Members: 11-Dist. 6	S. S. Kurella McDow Med. Cntr., Maple Summit Rd., Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
JO DAVIESS Members: 8-Dist. 12	Wilbur Johnson 300 Summit St., Galena 61036	David Hockman 300 Summit St., Galena 61036
KANE Members: 305-Dist. 1 Michael Wild, Ex. Dir. 202 Campbell Geneva 60134	Gerald J. Liesen 606 S. Riverside, St. Charles 60174	William T. Sheehy 1187 Dundee Ave., Elgin 60120
KANKAKEE Members: 107-Dist. 11	Morris Lang 1309 E. Court St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
KENDALL Members: 7-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 74-Dist. 4	Duane A. Willander 575 N. Kellogg St., Galesburg 61401	J. John Loesch Galesburg Cottage Hosp., Galesburg 61401
LAKE Members: 387-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	David B. Littman 363 Park Ave., Glencoe 60022	Edward L. Leslie 935 Glen Flora Ave., Waukegan, 60085

COUNTY	PRESIDENT	SECRETARY
LA SALLE Members: 113-Dist. 2	Mavis Schraudenbach 24 Stacy, Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 10-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Alexander Po R.R. #2, Lawrenceville 62439
LEE Members: 29-Dist. 12	Wilbur L. Stitzel KSB Hosp., 403 E. First St., Dixon 61021	Joseph Elie McNichols Clinic, 101 W. First St., Dixon 61021
LIVINGSTON Members: 28-Dist. 2	Roger K. Kipfer 109 W. Howard St., Pontiac 61764	Karl T. Deterding 612 E. Water, Pontiac 61764
LOGAN Members: 24-Dist. 5	Glen Tomlinson #4 Doctor's Park, Lincoln 62656	Robert B. Perry 523 N. Elm, Lincoln 62656
MACON Members: 159-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Ezra Beyda 2220 N. Monroe, Decatur 62526	H. L. Wibbels 2300 N. Edward, Decatur 62526
MACOUPIN Members: 21-Dist. 6	John Ubben Community Mem. Hosp., Staunton 62088	Robert England 224 E. Main, Carlinville 62626
MADISON Members: 188-Dist. 6	Robert Hamilton State & Wall Streets, Alton 62002	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 40-Dist. 7	Edward F. Stephens 126 S. Lincoln, Centralia 62801	W. P. Plassman Box 552, Centralia 62801
MASON Members: 6-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	
MASSAC Members 3-Dist. 9	Jack D. Diles Massac Mem. Hosp., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
MCDONOUGH Members: 34-Dist. 4	Samuel M. Gines 505 E. Grant, Macomb 61455	David Reem 505 E. Grant, Macomb 61455
McHENRY Members: 79-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Daniel E. Horan 527 W. South St., Woodstock 60098	Stanley S. Chmiel 1110 N. Green St., McHenry 60050
McLEAN Members: 123-Dist. 5 Bernyce Carbery Exec. Sec. 401 W. Virginia Normal 61761	Hans Stroink 900 Franklin, Normal 61761	Douglas R. Bey 900 Franklin Ave., Normal 61761
MERCER Members: 6-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	
MONROE Members: 10-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	Chung H. Khan Box 142, Lakeview Dr., Waterloo, 62298
MONTGOMERY Members: 21-Dist. 5	Walter R. Williams 524 S. Main, Hillsboro 62049	James T. Foster 8 Arrowhead Rd., Litchfield 62056
MORGAN-SCOTT Members: 49-Dist. 6	Omar Panella 1440 W. Walnut, Jacksonville 62650	J. D. Winterhalter 43 Ivywood Dr., Jacksonville 62650
MOULTRIE Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951

COUNTY	PRESIDENT	SECRETARY
OGLE Members: 15-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 363-Dist. 4 M. John Hanni, Jr., Ex. Sec. 427 1st National Bank Peoria 61602	William H. Marshall 427 1st Nat'l. Bank Bld., Peoria 61602	John W. Berney 427 1st Nat'l. Bank Bld., Peoria 61602
PERRY Members: 14-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 4-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 10-Dist. 6	Myer Shulman 112 W. Jefferson St., Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 22-Dist. 10	Stephen M. Platt 1101 George St., Chester 62233	J. M. Whittenberg 1650 State St., Chester 62233
RICHLAND Members: 23-Dist. 8	Michael E. Murray 1200 N. East, Olney 62450	Arcot D. Suresh Weber Medical Clinic, 1200 N. East St., Olney 62450
ROCK ISLAND Members: 203-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	Earl H. Clark 2701 17th St., Rock Island 61201	Marvin L. Skoglund 4602 Third St., Moline 61265
ST. CLAIR Members: 261-Dist. 10 Ed Belz, Ex. Sec. 4825 W. Main Belleville 62223	Lloyd E. Thompson 4601 State St., E. St. Louis 62205	Michael Murphy 6401 W. Main, Belleville 62223
SALINE-POPE-HARDIN Members: 33-Dist. 9	H. Andrew Cserny 1405 Locust, Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
SANGAMON Members: 327-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	Robert P. Johnson 108 Maple Grove, Springfield 62707	Towfig Arjmand 1307 S. 7th St., Springfield 62703
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 9-Dist. 7	Theodore Little 207 S. Pine, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
STEPHENSON Members: 54-Dist. 12	Frank Des Courouez 3103 W. Stephenson, Freeport 61032	Karl Schwiesow 220 W. Exchange, Freeport 61032
TAZEWELL Members: 66-Dist. 5 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	H. Don Blair P.O. Box 778, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
UNION Members: 6-Dist. 9	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting 525 N. Main, P.O. Drawer 559, Anna 62906
VERMILION Members: 103-Dist. 8	John C. Mason, Jr., 715 N. Logan, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
WABASH Members: 6-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863

COUNTY	PRESIDENT	SECRETARY
WARREN Members: 14-Dist. 4	Richard Icenogle Box 188, Roseville 61473	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 9-Dist. 10	Ralph Kelly 113 W. St. Louis, Nashville 62263	Ousama Ghaibeh Box 197, Irvington 62848
WAYNE Members: 9-Dist. 9	Charles J. Jannings 101 E. Center, Fairfield 62837	Arthur R. Marks 101 E. Center St., Fairfield 62837
WHITE Members: 7-Dist. 9	Morris McCall South Plum St., Carmi 62821	Phillip D. Boren South Plum St., Carmi 62821
WHITESIDE Members: 55-Dist. 12	Carmelo V. Interone 14 E. Miller Rd., Sterling 61081	Richard A. Londo 204 N. Jackson, Morrison 61270
WILL-GRUNDY Members: 230-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Alex J. Spadoni 2301 Glenwood, Joliet 60435	T. M. Kanellakes 2112 W. Jefferson St., Joliet 60435
WILLIAMSON Members: 36-Dist. 9	Norman Albert 126 W. Broadway, Johnson City 62951	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Jerald L. Johnson Exec. Sec. Members: 408-Dist. 12 310 N. Wyman St. Rockford 61101	Richard S. Webb, Jr. 2500 N. Rockton, Rockford 61103	Bernard O'Malley 5670 E. State St., Rockford 61108
WOODFORD Members: 7-Dist. 2	Ronald L. Meyer 101 E. Broad St., Roanoke 61561	James W. Riley 109 S. Major, Eureka 61530
No Organized County Society		Joint County Societies
Edwards		Cass-Brown
Johnson		Coles-Cumberland
Marshall		Henry-Stark
Menard		Jefferson-Hamilton
Putnam		Jersey-Calhoun
		Morgan-Scott
		Saline-Pope-Hardin
		Will-Grundy

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

Agenda

1979 House of Delegates

Cyril C. Wiggishoff, M.D. *Speaker*

Robert P. Johnson, M.D. *Vice-Speaker*

FIRST SESSION

1:00 p.m.—Sunday, May 6, 1979

Red Lacquer Room

Palmer House

Chicago

1. Call to order
Cyril C. Wiggishoff, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for deceased members since April, 1978 conducted by Audley F. Connor, Jr., M.D., *Secretary-Treasurer*
7. Report of Chairman, Board of Trustees
Robert R. Hartman, M.D.
8. Remarks of Speaker
9. Resolutions and supplementary reports
10. New business and announcements
Reference Committees—2:00 p.m.
Delegates' Buffet—6:30 p.m.
11. Recess until 2:30 p.m.—Monday, May 7, 1979

SECOND SESSION

2:30 p.m.—Monday, May 7, 1979

Red Lacquer Room

Palmer House

Chicago

1. Call to order by speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests
Mrs. Earl Klaren, *President*, Illinois State Medical Society Auxiliary
Mrs. Leslie Lee, *President*, Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
6. Presentation of certificates of appreciation to Continuing Medical Education Examiners
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report
Herbert Sohn, M.D., *Chairman*
9. Report of Executive Administrator
Mr. Roger N. White
10. Introduction of AMA Delegates and Alternate Delegates
Herschel Browns, M.D., *Chairman*
11. President's Address
David S. Fox, M.D.
12. New business and announcements
12. Recess until 10:00 a.m.—Tuesday, May 8, 1979

THIRD SESSION

10:00 a.m.—Tuesday, May 8, 1979

Red Lacquer Room

Palmer House

Chicago

1. Call to order by the speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Announcements and introduction of guests
6. Reports of Reference Committees
 - Amendments to Constitution and Bylaws
 - Committee A—Officers, Administration, Finances and Budgets
 - Committee B—Government Health Programs, including National Health Insurance and Cost Containment
- Committee C—Education, Manpower and Clinical Medicine
- Committee D—Medical Service and Economic Matters Outside of Government Programs
- Committee E—Governmental Affairs and Medical Legal
- Committee F—Public Relations, Membership and Miscellaneous Business
7. Recess for luncheon
8. Reconvene 2:00 p.m.
9. New Business
10. Recess until 9:00 a.m.—Wednesday, May 9, 1979

FOURTH SESSION

9:00 a.m.—Wednesday, May 9, 1979

Red Lacquer Room

Palmer House

Chicago

1. Call to order by the Speaker
 2. Invocation
 3. Report of Committee on Rules and Order of Business
 4. Report of Credentials Committee
 5. Induction of P. John Seward, M.D., President-Elect into office of President by David S. Fox, M.D.
 6. Address of President Seward
 7. Announcements and introduction of guests
 8. Reports of reference committees
 9. Elections
 - Report of Nominating Committee
 - (a) President-Elect (CMS)
 - (b) 1st Vice President (DS)
 - (c) 2nd Vice President (CMS)
 - (d) Secretary-Treasurer
 - (e) Speaker of the House (DS)
 - (f) Vice Speaker (CMS)
 - (g) Trustees
 - Terms Expiring*
 - Howard C. Burkhead, M.D.
 - Herschel Browns, M.D.
 - Jack Gibbs, M.D.
 - Theodore Grevas, M.D.
 - Morgan M. Meyer, M.D.
 - Joseph H. Skom, M.D.
 - Fred A. Tworoger, M.D.
 - (i) One new delegate to be elected to take office January 1, 1980, and serve until December 31, 1981
 - (j) Alternate Delegates to AMA to take office January 1, 1980, and serve until December 31, 1981
 - Terms Expiring*
 - Robert R. Hartman, M.D.
 - Eugene P. Johnson, M.D.
 - Lee Johnson, M.D. (resigned)
 - Maynard I. Shapiro, M.D.
 - Andrew Thomson, Jr., M.D. (resigned)
 - Glen E. Tomlinson, M.D.
 - Cyril C. Wiggishoff, M.D.
 - George T. Wilkins, M.D.
 - (k) One new alternate delegate to be elected to take office January 1, 1980, and serve until December 31, 1981
 - (l) One alternate delegate to take office immediately to fill unexpired term of Lee Johnson, M.D.
 - (m) One alternate delegate to take office immediately to fill unexpired term of Andrew Thomson, Jr., M.D.
- | DISTRICT | TERMS EXPIRING |
|----------|-------------------------|
| Third | Jere Freidheim, M.D. |
| Third | Alfred Clementi, M.D. |
| Third | Robert T. Fox, M.D. |
| Fourth | Fred Z. White, M.D. |
| Fifth | Paul F. Mahon, M.D. |
| Seventh | Alfred J. Kiessel, M.D. |
| Eighth | James Laidlaw, M.D. |
- (h) Delegates to AMA to take office January 1, 1980, and serve until December 31, 1981
 10. Fixing of per capita dues for 1980
 11. Selection of meeting place and time for next meeting
 12. Unfinished business
 13. New business
 14. Adjournment, Sine Die

Committees of the House of Delegates

1979 Annual Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

REFERENCE COMMITTEE B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

REFERENCE COMMITTEE C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

REFERENCE COMMITTEE D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

REFERENCE COMMITTEE E

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

REFERENCE COMMITTEE F

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.

Program Summary By Days

ISMS Annual Meeting

May 5-9, 1979

Palmer House, Chicago

Saturday, May 5, 1979

- 8:30 a.m. Resident Physicians Section
- 9:00 a.m. Board of Trustees Meeting
- 1:00 p.m. Student Business Session
- 2:00 p.m. Alcoholism and Drug Seminar

- 2:00 p.m. ISMIE Board Meeting
- 2:00 p.m. Credentials Committee
- 2:30 p.m. House of Delegates
- 4:30 p.m. IMPAC Annual Meeting
- 5:00 p.m. Downstate Caucus
- 5:00 p.m. C.M.S. Caucus

Sunday, May 6, 1979

- 7:30 a.m. AMA Delegation Meeting
- 7:30 a.m. Preventive Medicine Breakfast
- 8:00 a.m. Registration
- 9:00 a.m. AMA Briefing for ISMS Leaders
- 10:00 a.m. Meeting of Reference Committee Members
- 11:00 a.m. District Meetings
- 12:00 noon Credentials Committee
- 1:00 p.m. House of Delegates
- 2:00 p.m. Reference Committees
- 6:30 p.m. Delegates Buffet

Tuesday, May 8, 1979

- 7:30 a.m. CIMA Breakfast
- 7:30 a.m. Board of Trustees Meeting
- 8:00 a.m. Registration
- 9:00 a.m. District Meetings
- 10:00 a.m. House of Delegates
- 12:00 noon Recess
- 2:00 p.m. House of Delegates
- 6:30 p.m. President's Reception and Dinner

Monday, May 7, 1979

- 7:30 a.m. ISMS-IMPAC Public Affairs Breakfast
- 8:00 a.m. Registration
- 9:00 a.m. Illinois Society of Pathologists
- 9:00 a.m. ICCME Workshop
- 12:00 noon Fifty Year Club
- 1:00 p.m. ISMIE Membership Meeting

Wednesday, May 9, 1979

- 7:30 a.m. CIMA Breakfast
- 7:30 a.m. Board of Trustees Meeting
- 8:00 a.m. Registration
- 8:30 a.m. Credentials Committee
- 9:00 a.m. House of Delegates
Board of Trustees Reorganization Meeting
immediately following House adjournment

Resolutions

May, 1979, Annual Meeting

House of Delegates

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>
79M-1	Clifton L. Reeder, M.D., for the Chicago Medical Society	Refusal of Third Party Payers to Pay for Reconstructive Surgery of the Breast to Correct Deformities
79M-2	Ernest Adams, M.D.	Distribution of Information Regarding Dues and Assessments
79M-3	Richard Rudman, M.D., for the Marion County Medical Society	Unified Membership with AMA

ISMS DELEGATION TO THE AMA

Delegates

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Joseph Skom, Chicago
Fred A. Tworoger, Chicago

To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)

Allison L. Burdick, Jr., Chicago
Henrietta Herbolsheimer, Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John Ring, Mundelein
Charles K. Wells, Mt. Vernon

Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, Harrisburg

Delegation Chairman: Herschel Browns; Secretary: Theodore Grevas

Alternate Delegates

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Maynard I. Shapiro, Chicago
Andrew Thomson, Jr., Evanston
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Granite City

To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford
Clifton L. Reeder, Chicago

ISMS Auxiliary Fifty-First Annual Meeting, Palmer House, Chicago

Saturday, May 5, 1979

2:00-5:00
4:00-5:00

ISMS Seminar on Youth and Chemical Dependency
ISMS Auxiliary Budget Committee Meeting

Sunday, May 6, 1979

11:30 am

Pin & Gavel Luncheon (Past Presidents only)
Consulate Room—Continental Plaza

2-4 pm

Registration

Sixth Floor

3:30

Pre-Convention Board Meeting

Chicago Room (Lower Level)

5:30

Board Dinner (guests welcome)

Luau Room (Lower Level)

8:30

Reception honoring Members-at-Large

Hospitality Room

Monday, May 7, 1979

7:30 am

ISMS-IMPAC Public Affairs Breakfast (Tickets available at ISMS registration desk)

Speaker: *US Senator Roger Jepsen*

Topic: "An Overview of National Health Issues"

8-4 pm

Registration

Sixth Floor

9 am

Opening Session—House of Delegates

Adams Room

Welcome—*Mrs. W. J. Olszewski, President, CMS Auxiliary*

Response—*Mrs. Luben Atzeff, Convention Co-Chairman*

Pledges—*Mrs. R. S. Hoover, President-Elect*

Introduction of special guests: *Mrs. Harlan Failor*

Greetings from ISMS Officers

Introduction of Keynote Speaker

Keynote Address—*Mrs. Manuel A. Bergnes, President, AMAA*

Business

11 am

Special Program—"Reading, Writing & Reefer" reported by *Edwin Newman of NBC*

Introduction—*Mrs. James Gwaltney*

Panel—*Dr. Sidney Cohen, Director of Marijuana Studies, UCLA School of Medicine*

Robert Taylor, Assistant Director of Metropolitan Narcotics Enforcement Group,

Cook County Sheriff's Police

Father Charles Cronin, Suburban & Innercity Youth Director

1 pm

President's Luncheon

State Ballroom

Honoring Past State Presidents—County Presidents—Guests

Program—"Le Petite Ballet" of Lyric Opera & Nutcracker Suite

2:30 pm

Second Session—House of Delegates

Adams Room

Film—"A Critical Difference"

Speaker: *Addy Weinstein, Regional Director of Medic Alert Foundation*

Topic: Why "Medic Alert"?

Business

6 pm

Tour-by-Twilight bus leaves for dinner & Second City Theatre

11:30 pm

Return to Palmer House

Tuesday, May 8, 1979

8-4 pm

Registration

Sixth Floor

9 am

Third Session—House of Delegates

Adams Room

Business

Annual Awards

Reports

Memorial Service—*Mrs. Henry Schorr*

"Focus on Auxiliary"

Mrs. R. S. Hoover, President-Elect

Preview of 1979-80 programs

12:30 pm

Installation Luncheon

State Ballroom

Musical Entertainment

Installation of new state officers—*Mrs. Manuel A. Bergnes, President AMAA*

Humanitarian Award—*Mrs. Richard Hawkins*

Installation of Host county officers—*Mrs. Morris Stein*

3:30 pm

Post-Convention Board Meeting

Adams Room

4:30 pm

Gala Reception

Hospitality Suite

To honor newly elected state and host county officers

6:30 pm

ISMS President's Night Dinner

Red Lacquer Room

Reception

Dinner

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

March 1, 1979

NOTIFICATION OF IMPAC ANNUAL MEETING

The 1979 annual meeting of the Illinois Medical Political Action Committee will be held on Tuesday, May 8, 1979, immediately following the adjournment of the Second Session of the ISMS House of Delegates:

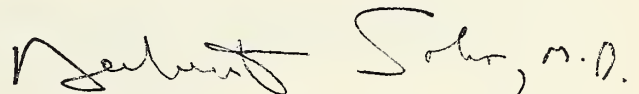
4:30 p.m. (approximate time)
Red Lacquer Room
Palmer House
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1979 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

Terms Expiring 1982

E. J. Jacobs, M.D.	Arlington Heights
Frank J. Jirka, Jr., M.D.	Barrington
James Laidlaw, M.D.	Champaign
Tassos Nassos, M.D.	Northbrook
Edward Ragsdale, M.D.	Godfrey
Clifton L. Reeder, M.D.	Chicago
Michael Ruane, M.D.	Chicago
Willard C. Scrivner, M.D.	Belleville
Earl Suckow, M.D.	Mt. Prospect
Fred A. Tworoger, M.D.	Chicago



Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

ISMS Workshop

Youth and Chemical Dependency

Saturday, May 5, 1979

2:00—5:00 p.m.

- 2:00** Edward Senay, M.D., professor of psychiatry with the University of Chicago Hospitals, and former chief of their Psychiatric Consultation Service, will discuss trends in substance abuse. Dr. Senay, former executive director of Substance Abuse Services, Inc., and former director of the Illinois Drug Abuse Program, is a member of the Editorial Board for the American Journal of Drug and Alcohol Abuse. He will discuss data indicating that misuse of drugs by both sexes appears to be occurring at a younger age, and involving a wider range of substances.
- 3:00** Lee Gladstone, M.D., director of the Alcoholism Treatment Program, Institute of Psychiatry, Northwestern Memorial Hospital and an assistant professor of psychiatry at Northwestern University, will discuss epidemiological aspects, diagnosis and treatment modalities for the youthful substance abuser. Dr. Gladstone is a practicing private psychiatrist and former director of the Northwestern Memorial Psychiatric Day Hospital.
- 4:00** John E. Mayer, Ph.D., a psychologist affiliated with Northwestern University Medical School and member of the youth division of the citizens' advisory board on alcoholism will discuss the nature of adolescence and its relationship to alcohol misuse. The speaker is a national consultant to the National Institute on Alcohol Abuse and Alcoholism.

This program is held in conjunction with the ISMS House of Delegates 1979 Annual Meeting at the Chicago Palmer House. Hour-for-hour Category 2 continuing medical education credit is available to participants.

This workshop is sponsored by the ISMS Committee on Alcoholism and Drug Dependence, with the support of a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism.

For further information, please contact the ISMS offices.

CALLS WILL REACH YOU EASILY AT THE 1979 CONVENTION

Doctor, please inform your staff that while you are attending the ISMS annual meeting, you may be reached through the Physician's Message Center from 10 a.m. to 5 p.m. Sunday and from 9 a.m. to 4:30 p.m. Monday through Wednesday at this number:

312-236-8750

This is a direct connection which will not go through the hotel switchboard.

Schedule of Associated Meetings

Resident Physicians Section

Seminar: Establishing Yourself in Private Practice

Saturday, May 5, 1979

8:30 a.m.-11:00 a.m.

1:00 p.m.- 5:00 p.m.

Conducted by Robert J. Kramer, M.D.

For registration information, please contact ISMS headquarters
RPS Annual Business Meeting and election of officers: 11:00 a.m.

Third Annual Workshop for CME Accreditation Surveyors

Monday, May 7, 1979

9:30 a.m.-12:30 p.m.

- Update on new policies of Liaison Committee/CME
 - Third version of Self-Analysis
 - Exchange of ideas and experiences
-

Illinois State Medical Inter-Insurance Exchange Annual Meeting of Members

Monday, May 7, 1979

1:00 p.m.

- Election of Board of Governors
 - Ratification of auditors selected for coming year
 - New business
-

Illinois Society of Pathologists

Monday, May 7, 1979

9:00 a.m.

Featured Speaker:

A. Bernard Ackerman, M.D., Head, Dermatopathology
Section, Skin & Cancer Unit, New York University
Medical Center

"Histological Diagnosis of Inflammatory Skin Disease"

CONVENTION '79

The 139th Annual Meeting
of the
Illinois State Medical Society
will be held at the
Palmer House, State and Monroe
Chicago, Illinois
May 6-9, 1979

- ISMS House of Delegates
 - Specialty Society Scientific Programs
 - Gala President's Party
 - Annual IMPAC Meeting
 - Public Affairs Breakfast

Further information about Convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

PLAN NOW TO ATTEND CONVENTION '79

May 6-9, 1979, Palmer House, Chicago

For reservations, check accommodations desired and mail to:

Palmer House - Reservation Department
State and Monroe Streets
Chicago, Illinois 60690

Name _____

Company Name ILLINOIS STATE MEDICAL SOCIETY & AUXILIARY ANNUAL MEETING

Address _____

City _____ State _____ Zip _____

Arrival _____ Hour _____ ^{am} pm Departure Date _____

Single	—\$50	—\$55	—\$60	—\$65	—\$70
Double	—\$65	—\$70	—\$75	—\$80	—\$85
Twin	—\$65	—\$70	—\$75	—\$80	—\$85
Parlor and 1 Bedroom Suite				—\$145 & up	
Parlor and 2 Bedroom Suite				—\$225 & up	

					Palmer House Towers
Single	—\$60	—\$65	—\$85	—\$95	
Double	—\$75	—\$80	—\$85	—\$95	
Parlor and 1 Bedroom Suite			—\$175 & up		
Parlor and 2 Bedroom Suite			—\$275 & up		

For better choice of accommodations, early reservations are suggested. If rate requested is not available, the next available rate will be confirmed. Rooms will held until 6:00 p.m. on stated date of arrival, unless a later time is confirmed.

All room rates are subject to additional 6.1% charge to cover Illinois hotel operators' occupation tax and Chicago hotel operator's tax, as well as a 2% Chicago accommodations tax imposed by the city of Chicago.
ISMS CONVENTION DATES 5/6-5/9/79

ILLINOIS STATE MEDICAL SOCIETY

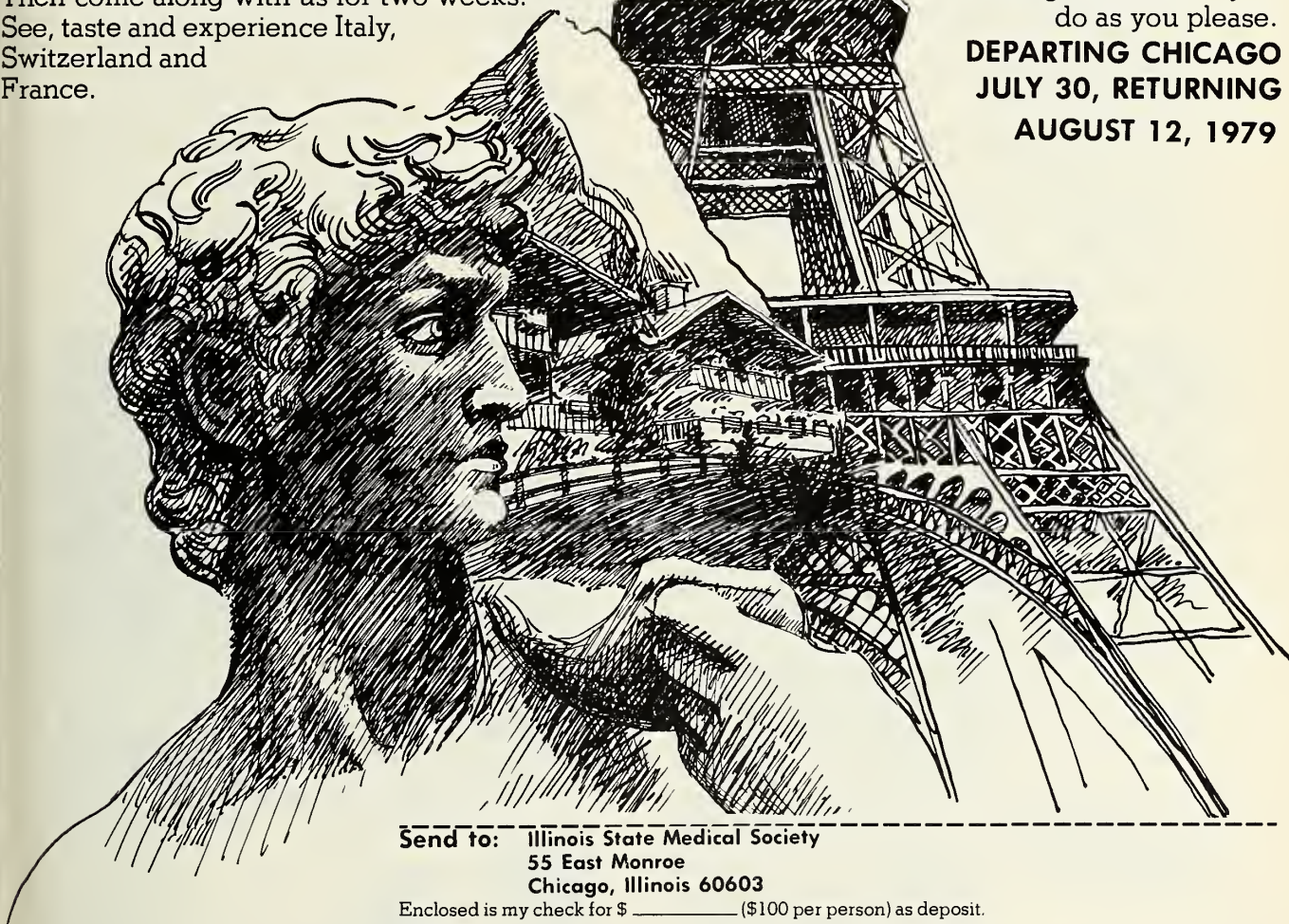
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JULY 30, RETURNING
AUGUST 12, 1979**



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Chicago, Illinois 60603

Enclosed is my check for \$ _____ (\$100 per person) as deposit.

Names _____

Address _____

City _____

State _____

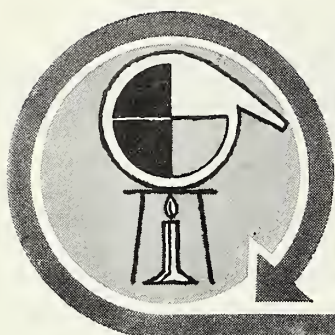
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Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICAL ENTITIES

Bretylum tosylate	(<i>BRETYLOL</i> , Arnar-Stone) Rx
Therapeutic Class:	Antiarrhythmic
FDA Approval:	July, 1978
Chemistry:	o-bromobenzyl ethyldimethylammonium p-toluene sulfonate
Supplied:	Ampules, 50 mg/ml, 10 ml
Indications:	Treatment of life-threatening ventricular arrhythmias, principally ventricular fibrillation and ventricular tachycardia that have not responded to adequate doses of lidocaine or procainamide
Contraindications:	None in the treatment of ventricular fibrillation or life-threatening refractory ventricular arrhythmias
Dosage:	5 mg/Kg directly IV 5-10 mg/Kg IV infusion with dilution solution 5-10 mg/Kg IM
Diflorasone Diacetate	(<i>FLORONE</i> —Upjohn) Rx
Therapeutic Class:	Corticoids—local
FDA Approval:	July, 1978
Chemistry:	6 α 9-Difluoro-11 β ,17,21-trihydroxy-16 β -methylpregna-1,4-diene-3,20-dione 17,21-diacetate.
Supplied:	Cream, 0.05% Ointment 0.05%
Indications:	Adjunctive therapy for the relief of inflammatory manifestations of acute and chronic corticosteroid-responsive dermatoses

Contraindications:	Varicella and vaccinia; hypersensitivity to any of the individual components
Administration:	See package insert
Dobutamine HCl	(<i>DOBUTREX</i> —Eli Lilly) Rx
Therapeutic Class:	Cardiotonics
FDA Approval:	July, 1978
Chemistry:	(1)-4- {2-[(3-(P-hydroxyphenyl)-1-methylpropyl) amino] ethyl}-pyrocatechol hydrochloride
Supplied:	Vials, 250 mg/20ml (lyophilized)
Indications:	Short-term treatment of adults with cardiac decompensation due to depressed contractility resulting either from organic heart disease or from cardiac surgery
Contraindication:	Idiopathic hypertrophic subaortic stenosis
Dosage:	Rate of infusion ranges from 2.5 to 10 mcg/Kg/min

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Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 1, 1978.

Case Report: Trauma

Dr. John Beal: We will divide this discussion into three areas: trauma of the head, abdominal trauma, and trauma of the genitourinary tract. These are three common areas of serious injury. There are certain basic principles in the management of such injuries with which surgeons should be familiar. Dr. Leonard Cerullo, neurosurgeon, will discuss head trauma.

Dr. Leonard Cerullo: Initial evaluation of the head injured patient, as initial evaluation of any injured patient, first should consider the respiratory and cardiovascular function and associated injuries. Respiratory exchange is particularly important in the head injured patient because of its role in the maintenance of the intracranial pressure and the fragile cerebral metabolic state. It serves as a major prognostic criterion. If there is any question about the patency of the airway or deterioration of the neurological condition because of airway obstruction, the patient should be intubated immediately.

The initial neurologic evaluation can be very simple. The patients may be divided in two groups; those who are not sick and those who are sick, although there are actually four stages of closed head injury. It must be emphasized that we are not discussing penetrating head injuries.

Stage I: The patient has suffered a concussion. He has lost consciousness as a result of the

head injury, but at the time of his examination he is neurologically normal.

Stage II: The patient has lost consciousness and at the time of the examination is somewhat obtunded, drowsy, and perhaps confused, but is able to verbalize. Stage I and Stage II patients are best handled in an orderly fashion. After the initial examination and neurologic appraisal, skull X-rays are taken to determine if fracture lines are present, especially fractures which cross the major vascular structures such as the superior sagittal sinus, and the middle meningeal artery, and to rule out depressed fractures and pneumocephalus. Cervical spine X-rays are obtained because of the frequent occurrence of cervical spine injury in patients with head trauma. Following these studies, the patient is admitted and observed for evidence of deterioration of the level of consciousness, change in motor power, pupillary equality, and vital signs, particularly for hypertension and/or bradycardia. No mydriatics or CNS depressants are allowed.

Stages III and IV: Those patients who are obtunded and not responsive to command are first evaluated by the neurologic examination. Note is made of the level of response to noxious stimuli and pupil response to light. Once a baseline has been obtained, cervical spine X-rays are taken in

the AP and lateral projections. This is done before the Doll's eye response is tested, although caloric stimulation can be performed without prior cervical spine X-rays. The airway is assured and the patient is hyperventilated if need be. A CT scan is now performed to determine the presence or absence of an intracranial space occupying lesion, such as hematoma or lobar edema. Following the CT scan, surgical lesions are dealt with. If there is not evidence of hematoma, the patient is taken to the operating room where an intracranial monitoring device is inserted.

What is the importance of intracranial pressure in head injury? In patients with severe head injury, those in groups III and IV, if intracranial pressure can be controlled, approximately 75% will recover. If intracranial pressure cannot be controlled, approximately 75% of the patients will remain either in a neuro-vegetated state or expire. It is obviously very critical to monitor the intracranial pressure and to institute measures to control it.

Several methods are available to determine intracranial pressure. Probably the most accurate is the placement of a catheter in the lateral ventricle. This is more invasive so we have chosen to use a communication with the subarachnoid space over the convexity, the so-called Richmond screw. This can be established either in the operating room or in the Intensive Care Unit, and gives us a fairly reliable determination of intracranial pressure. Because the brain is in a closed box, intracranial pressure is really a function of volume. However, intracranial pressure does not rise until the compensatory mechanisms of the brain have been used up. The compensatory mechanisms of the brain regulate increasing intracranial volume whether it be caused by hematoma, edema, water, or tumor.

These mechanisms include (1) displacement of spinal fluid, (2) dehydration of the intracellular and interstitial spaces, and (3) diminution in the stagnant vascular volume (not in cerebral blood flow, but in intravascular volume). When these compensatory mechanisms, which are time-dependent, are spent, very slight increases in intracranial volume (as little as .2 cc) can result in a marked increase in intracranial pressure. Of course, when intracranial pressure approaches systemic blood pressure, then cerebral perfusion pressure which is the algebraic sum of the two, falls and eventually will reach the point where irreversible tissue ischemia occurs.

Ischemia

Does this irreversible tissue ischemia have to

be generalized? Usually it is a localized form of ischemia, which is the result of brain shift. An example is herniation of the temporal lobes through the tentorial incisura with pressure on the mid-brain and relative ischemia of the mid-brain. The same can occur at the other major foramen in the skull, the foramen magnum. There may be herniation of the cerebellar tonsils through the foramen magnum with pressure against the brainstem which results in brainstem ischemia and cardiovascular collapse. The classic methods to prevent increased intracranial pressure include hyperventilation and osmotic diuresis. Hyperventilation causes cerebral vasoconstriction and, therefore, mimics one of the normal compensatory mechanisms, that is, the reduction of intravascular volume. Mannitol® and other osmotic diuretics mimic the second compensatory mechanism, dehydration of the intracellular and interstitial compartments. The classic dose of Mannitol is 1-2 gm/kg. Recently, however, it has been discovered that a dose of .3 mg/kg. is as effective as the larger dose and causes less difficulty with osmotic imbalance. Removal of ventricular fluid is of course possible only if a catheter is present within the ventricle. Occasionally, the removal of as little as 1cc of cerebral spinal fluid can be lifesaving.

The role of glucocorticoids in head injury is questionable. It has never been shown that glucocorticoids, namely Decadron®, are effective in routine doses in the management of cerebral edema secondary to head injury. They are unquestionably effective in cerebral edema from brain tumor, particularly metastatic tumor, but their role in traumatic edema has not been proven. Approximately a year ago, two studies were reported in which massive doses (100mg. initially followed by 8mg/every two hours) of Decadron were administered to severely head injured patients. In this group, there were fewer increases in intracranial pressure over a period of time among the patients who received massive doses of Decadron and, therefore, we have adopted this therapy.

Precautions

What should be avoided in management of head injured patients? Anything which will increase venous pressure will be deleterious to head injured patients. This includes the Trendelenburg position, too abrupt turning of the head because of decreased drainage through the jugular veins, PEEP (particularly in hypovolemic patients), and vigorous suctioning if the patient is not adequately sedated. Extremes of blood pressure are to be avoided because of protein leakage into the extra

vascular space in hypertension and diminished cerebral perfusion in hypotension. Inadequate oxygenation secondary to pulmonary embolization or pneumonia is obviously deleterious. Seizures are also to be avoided because they increase metabolic needs, increase venous pressure, and interfere with adequate oxygenation during the apneic phase.

Recently, we have adopted two new forms of treatment which appear to have promise. Barbiturates have long been known to diminish intracranial pressure by causing cerebral vasoconstriction. They also act on the brain in some unknown fashion, perhaps through metabolic pathways, to make the brain more resistant to anoxia and anoxic insult. For this reason, we have begun to give a controlled form of barbiturate coma in severely head injured patients by which the patient is heavily sedated until the EEG slows to 5-6 cycles/sec. or even becomes "flat." Of course, the clinical examination of these patients is not applicable, and one has to rely entirely on measurements of intracranial pressure and intracranial compliance. While the patient is heavily barbiturized, we reduce his core body temperature to approximately 30°C. This has the added effect of decreasing metabolic requirements by about 50%. Our experience with these two forms of therapy has been very encouraging so far. There are many problems related to serum electrolytes, osmolarity and pulmonary function which require constant surveillance. However, we feel that these two adjunctive forms of therapy may prove very valuable in managing the severely head injured patient.

Abdominal Trauma

Dr. John Beal: Dr. John Raffensperger, professor of surgery and chief of general surgery, Children's Memorial Hospital, will speak on problems associated with abdominal trauma.

Dr. John Raffensperger: I cannot overemphasize what Dr. Cerullo said about a complete examination of the patient before you focus on one system. Someone must be responsible for a complete examination of an injured patient. A child was brought to the emergency room who had been hit by a car, thrown into the air and struck the pavement. He had a couple of obvious fractures and the orthopedic surgeons were called. He had suffered a concussion and the neurosurgeons were called. His arms and legs were examined and X-rays of skull and extremities were obtained, but no one did a complete examination. Somebody still has to act as general practitioner and examine the whole patient who has been injured. That is

why my first question is: "Is he breathing?" Listen to the chest with the stethoscope to at least one respiration of each side. If you don't hear breath sounds on each side, you must consider the insertion of a chest tube.

Most patients who are injured badly enough to be brought to the Emergency Room should be examined for evidence of abdominal trauma and most require intravenous fluid. When abdominal injury is present, use the upper extremity for the intravenous site. There is nothing worse than performing surgery to close a hole in the inferior vena cava while somebody is pumping blood in a leg, and all that blood is coming out the hole in the vena cava. When you type and cross match blood for a traumatized patient, have at least six units available for a child and at least 12 for an adult. A nasogastric tube and a urinary catheter should be routine for a patient with abdominal trauma.

I have a favorite story about an experience in a trauma unit several years ago when I was asked to see a child with lower abdominal tenderness. I said to the resident, "Are there any red blood cells in the urine?" The resident turned to the intern and the intern shook his head. The resident said, "No red blood cells in the urine."

That afternoon on rounds, more tenderness. I looked at the resident and asked, "Are there red blood cells in the urine?" The resident shook his head. We had to explore the child anyway and there was an obvious rupture of the urinary bladder. I said, "For God's sake, who said there were no red blood cells in the urine?" The intern said, "No urine." This is to emphasize the point that urinalysis is essential for anyone who has been injured or is evaluated for operation. Obtain a urine sample, by catheter if necessary. The only contraindication for insertion of a catheter is gross blood at the meatus.

You can approach in an organized fashion. After you have done a complete physical examination, including the vital signs, then specifically examine the abdomen. Abdominal tenderness is probably the most important finding, whether the patient has a ruptured ulcer, perforated appendix, or trauma. The hematocrit is useful but changes sometimes after injury and blood loss. However, the initial hematocrit serves as a base line. If there is evidence of abdominal trauma, get a serum amylase immediately.

Finally, X-rays are over rated. Do all these other things first, then when you go to the X-ray department, you can obtain the required films at one time. A chest film is required in patients who are to have general anesthesia. After this initial evaluation, you have determined which patients

should go to the operating room and who should return to intensive care for additional observation.

There can be difficult diagnostic problems with blunt abdominal trauma. There are a number of ways to resolve these problems; the first still rests with a hospital bed, with someone coming around to feel the abdomen, check the pulse, and check the vital signs. Other diagnostic techniques include paracentesis, radioactive scans and ultrasound. The last is particularly useful in pancreatic trauma. Barium contrast studies are useful mainly in the delayed effects of gastrointestinal trauma. Angiography is employed infrequently. Peritoneal lavage is helpful in the patient who is uncooperative or injured.

The most common organ to be injured in blunt abdominal trauma is the spleen and the solution in the past had been to remove it. There has been great concern about postsplenectomy sepsis. Postsplenectomy sepsis indeed occurs after splenectomy for trauma. It has been found feasible to repair a badly damaged spleen. Repair may require Avitene® Surgicel® and sutures, but the spleen will stop bleeding and heal.

Now we try to avoid operation for splenic injury. In more than a year we have not taken out a ruptured spleen at Children's Memorial Hospital. We rely heavily on the scan. Our standard practice for children who are suspected of splenic injury is admission to the hospital, intravenous Ringer's lactate and a liver-spleen scan. I am impressed with the number of patients who turn up with a ruptured spleen and who have minimal clinical findings. We keep these patients at bed rest for a couple of weeks doing repeated spleen scans. Thus, it has been demonstrated that splenectomy is seldom required in children. An article in *Lancet* about six months ago described long term follow-up of World War II veterans whose spleens were removed for trauma and reported a high incidence of infectious problems.

Obviously, there are times when operation is necessary. A 17-year-old girl was trying to learn to drive a car and drove into a tree. She was admitted with deep shock, a distended abdomen and clearly had a major intra-abdominal catastrophe. A right hepatic lobectomy was performed. In retrospect, it might have been possible to have treated this patient with ligation of the right hepatic artery, debridement of devitalized tissue, and adequate drainage. However, even after right hepatic lobectomy, a liver scan several months later showed very good regeneration of the liver from the remaining left lobe.

I want to remind you of hemobilia, an uncommon

problem. In a patient who has had abdominal trauma followed by a triad of cramping right upper quadrant pain, an elevated bilirubin level and then vomits blood, suspect hemobilia. The diagnosis can be established by selective hepatic artery angiogram.

Injuries to the pancreas present another problem in management and diagnosis. The patient who has persistent abdominal tenderness, shock, and elevated amylase levels either in the urine or in the serum is likely to have a pancreatic injury. If at the time of operation you find a transected gland, a Roux-en-y loop of small bowel can be attached to the proximal end and the distal portion removed. More commonly, the gland is contused but intact and there is fluid in the lesser sac and much edema. In that situation, you *must* drain. Several large "cigaret" drains or a sump tube must be used and can be brought out of the flank. The drains can be placed along the pancreas below the spleen and must remain in place until drainage ceases—two to three weeks.

Renal Trauma

Dr. John Beal: Dr. John Grayhack, professor and chairman, department of urology, will discuss problems associated with renal trauma.

Dr. John Grayhack: Fortunately, most patients have been in excellent health until the time of renal trauma. As previously emphasized, maintenance of a patent airway and restoration of adequate circulation take precedence over other considerations. I will now review the findings that indicate trauma to the urinary tract, outline the proper evaluation and, briefly, appropriate patient management.

The primary indication of trauma to the urinary tract is blood in the urine, and Doctor Raffensperger's admonition that every injured patient who is examined in the Emergency Room should have urinalysis is pertinent. More than 90% of patients who have trauma to the urinary tract will have gross or microscopic hematuria. Unfortunately, not everyone who has trauma to the urinary tract does have hematuria. The pain which accompanies the trauma, if the patient is able to indicate the pain and the site to you, can certainly be useful in determining whether to suspect urinary tract trauma. Most patients who have renal injury have flank pain and, on physical examination have flank tenderness and muscle stress, indicating the presence of the injury in the area of the kidney.

Patients who have pelvic fractures have a high incidence of significant lower urinary tract trauma.

ma. High incidence is 5-15% in the various series, depending on the severity of pelvic fracture. That is a high incidence because it has contributing significance to the morbidity and mortality.

Once you suspect the presence of urinary tract injury, how do you evaluate the patient? Urinalysis is usually followed by X-ray studies. The X-ray studies of value are the intravenous pyelogram, the drip nephrotomogram, the arteriogram and the cystogram. The intravenous pyelogram is of value because it can indicate (1) the presence of a normal kidney on the uninjured side, which is impossible to judge at any operative exposure, (2) the presence of preexisting renal disease. (The patient who had hydronephrosis or renal tumor is much more prone to injury than the patient who has a normal urinary tract.), and (3) the presence of a traumatized organ.

The types of renal injury which occur include (1) contusion, (2) massive injury that causes bleeding, (3) laceration, which in general can be watched unless there is a persistent extravasation of urine. This may require drainage in the future and also is associated with blood in the urine, and (4) pedicle tear. The last often is not associated with blood in the urine. It is characterized by the presence of a mass in the upper quadrant that is expanding with recurrent evidence of blood loss. If pedicle tear has occurred, usually there will be no function on the intravenous pyelogram.

The intravenous pyelogram that is done in a traumatized patient and seriously ill need not be the extensive examination which is performed under ordinary circumstances. What it really requires is a plain film of the abdomen, which is essential to any type of diagnosis for abdominal trauma. The injection of contrast media is made in the usual amounts (not in amounts with the drip nephrotomography) and a single film made 10 to 15 minutes after the injection. It can be done on the way to the operating room. If the patient has not had a serious injury and has non-function indicated by intravenous pyelogram, there is indication for arteriography.

Ureteral injuries do occur. They are so unusual with blunt trauma that they hardly warrant any further discussion except to say that they are uncommonly associated with the presence of blood in the urine. Most ureteral injuries are secondary to manipulation, are iatrogenic in origin or may be associated with penetrating trauma, particularly from high speed missiles that are now common.

The last type of trauma that I wish to call to your attention affects the lower urinary tract and

is common to the bladder and lower urinary tract. In this instance, it is essential that if extravasation of urine has occurred, you recognize it promptly. If the patient's condition will permit, this extravasated urine should be drained promptly. Extravasation urine is tolerated poorly from the lower urinary tract in contrast to the upper urinary tract, where it is well tolerated for some reason. Before antibiotics were available, there was a progressive increase in mortality when extravasated urine was present from the lower urinary tract and drainage was not accomplished, comparable to that seen with perforated ulcer at that time. Thus, in each eight-hour period, there was a 50% increase in mortality. That does not seem to be true any longer because of the use of antibiotics; nevertheless, this is a life threatening situation and would take a high priority in patient management.

How do you recognize extravasated urine in the lower urinary tract? Usually, there will be blood, either in the urine if the tear is in the bladder or at the meatus if the urethra is injured. The common cause for urethral injury is pelvic fracture. The other cause of lower urinary tract injury is blunt trauma in the presence of a full bladder. An empty bladder ordinarily does not undergo disruption. The only way to make a definite diagnosis with lower urinary tract extravasation is to perform a cystogram. An attempt should be made to obtain an emptying film if the patient can void. If there is a disruption of the lower urinary tract, drainage must be instituted. You do not have to reconstruct the urinary tract and there is a considerable discussion about whether that should be done. My preference is to attempt to reconstruct if it can be accomplished easily. A catheter can be introduced through the bladder and passed out through the urethra. This catheter can be joined to a balloon in the bladder. Traction can be applied to the balloon. The bladder is drained suprapubically. With this type of maneuver, the vast majority of patients will have either no stricture or one that can be managed. If this cannot be done, drains must be inserted and the urinary tract can be reconstructed later.

In summary, when a patient is injured, urinalysis is essential. If there is blood in the urine or with particular types of injury such as pelvic fractures, it is essential that you evaluate the urinary tract by means of X-ray studies. The management of the patient will depend on the results of these X-ray studies and proper assessment of the patient. ◀



Illinois Society
American Association of Medical Assistants

Treasures of Knowledge

Illinois Governor James L. Thompson has again honored the Illinois Society, American Association of Medical Assistants, by proclaiming the week of April 22-29, 1979, as "Medical Assistants' Week" in Illinois.

The 23rd Annual Meeting of the Association will convene with a ribbon cutting ceremony on Thursday, April 26, 1979, at 8:00 p.m. in the Harvey Holiday Inn. (I-80 & I-294, Harvey, Illinois, (312) 596-1500.) The meeting will be hosted by the Southwest Suburban Cook County Chapter.

Non-member medical assistants are most welcome to participate.

Saturday's educational session will begin at 9:00 a.m., with a presentation entitled *Office Policy and Procedures* by Mrs. Cissy Egly, CMA, Joliet, Illinois Society president-elect.

National Debate on the Cost of Medical Care—The Issues and Challenges to Providers, will be the topic of a presentation by John B. O'Donoghue, Jr., M.D., a delegate to the AMA.

Mrs. Valerie Nowinski, ACSW, ACS, of the Palos Neuropsychiatric Institute will next discuss *Transactional Analysis Toward a Better Understanding of Self and Others*.

The educational portion will close on Sunday with a talk on *Certification and Revalidation* by AAMA Vice President Mrs. Dorothy Sellars, CMA-A, of Richmond, Virginia.

Business Meeting

Distinguished guests from the medical community will honor us by attending the opening session of the House of Delegates on Friday at 10:00 a.m., Mrs. Luella Mitchell, speaker of the house of delegates, presiding.

Chapter presidents will be welcomed by Mrs. Leslie Lee, Illinois Society president, on Friday at 8:00 p.m., during a festive banquet planned in their honor.

Special recognitions are scheduled during the Awards Luncheon, Saturday noon.

The Inaugural Banquet, scheduled for 7:30 p.m., on Saturday, will culminate the preceding year's accomplishments and honor incoming officers.

Registration fee is \$65.00 for total events; individual function tickets are also available. Please contact Ms. Ceil Kenny, convention chairman, at (312) 389-4252, or (312) 361-0010. Make checks payable to AAMA, Illinois Society Convention Fund, c/o Ms. C. Kenny, 11750 S. Homan Ave., Box 259, Merrionette Park, IL 60655. For overnight reservations please contact the hotel directly.

POSITION NOTICE

OBSTETRICS/GYNECOLOGY

Peoria School of Medicine

University of Illinois

College of Medicine

The discipline of Obstetrics/Gynecology, Peoria School of Medicine, University of Illinois College of Medicine, is seeking one or more physicians at the rank of Clinical Instructor or Clinical Assistant Professor to participate in pre-clinical and clinical instruction and to act as a preceptor for students within their own practice. The appointments are for 10-20% time. The University of Illinois is an Affirmative Action/Equal Opportunity Employer and encourages applications from members of minority groups and women. Closing date for applications is May 1, 1979. Send letter with curriculum vitae and names of three references to:

Brian A. Curtis, Ph.D., Coordinator for Educational Programs, Discipline of Obstetrics/Gynecology, Peoria School of Medicine, 123 S.W. Glendale Ave., Peoria, Illinois 61605.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

MAY

Basic Audit Seminars

BASIC AUDIT SEMINAR/PSYCHIATRIC AUDIT TEAM SEMINAR

For: Medical & mental health care professionals. Seminars, May 2-3, Indianapolis, Indiana. Sponsor: Indiana Hospital Association, 3921 N. Meridian St., Indianapolis 46208. Reg. deadline: 4/20. Fee: \$170. Reg. limit: none. Credit: AMA Category 1, 13½ hours; AMRA, 13½ hours. Contact: Jessica Manson. Phone: 317-926-1395.

Family Medicine

DIABETES

For: MD's. Lecture, May 15, 7:30 p.m., Elgin. Sponsor: Sherman Hospital, 934 Center St., Elgin 60120. Fee: none. Credit: AMA Category 1, 2 hours. Contact: Mary Anne Stiegemeier. Phone: 312-742-9800 x 649.

Family Medicine

MODERN CLINICAL-PATHOLOGICAL SPECTRUM OF ACUTE & CHRONIC HEPATITIS

For: FP's, Internists. Lecture, May 16, 2:00 p.m., Elmhurst. Speaker: Gregorio Cheifec, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard 60148. Reg. deadline: 5/14. Fee: none. Credit: AMA Category 1, 2 hours; AAFP Elective 2 hours. Contact: Lillian Widmer. Phone: 312-495-4050.

Family Therapy

PROBLEM-CENTERED SYSTEMS THERAPY—INTERVENTIONS

For: those who have attended PCST Assessment Course. 3-day workshop, May 16-18, Chicago. Speaker: William Pinsof, Ph.D. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$120. Reg. limit: 50. Contact: Jeanne Robinson. Phone: 312-649-7285.

Family Therapy

SEX ROLES AND FAMILY DYNAMICS

For: Psychiatrists, therapists. 1-day workshop, May 11, 9:30 a.m.-4:30 p.m., Chicago. Speaker: Larry Feldman, MD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$40. Reg. limit: 50. Credit: AMA Category 1, 6 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-649-7285.

Immunohematology

HEMOLYTIC DISEASE OF THE NEWBORN

For: MD's, nurses, technicians. Lecture, May 17, 7:00-9:00 p.m., Moline. Speaker: Edward Ogata, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., P.O. Box 70, Davenport, Iowa 52803. Fee: \$10, MD; \$2, others. Reg. limit: 200. Credit: AMA Category 1, 2 hours; AAFP Prescribed, 2 hours; AOA, 2 hours. Contact: Pat Harrod. Phone: 319-359-5401.

Medicine

MEDICAL STAFF WEEKLY CONFERENCES

For: MD's. Lectures, weekly, Fridays, May-July, 8:00 a.m., Granite City. Sponsor: St. Elizabeth Hospital, 2100 Madison Ave., Granite City 62040. Credit: AMA Category 1, 1 hour. Contact: J. B. Kopp, MD. Phone: 618-798-3000.

Medicine

ARTHRITIS AND RHEUMATOLOGY

For: MD's. Symposium, May 2, 1:00 p.m., Breese. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

HYPERTENSION SYMPOSIUM

For: MD's. Symposium, May 16, 8:00 a.m., Belleville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

ACUTE RESPIRATORY FAILURE/CHRONIC OBSTRUCTIVE PULMONARY DISEASE

For: MD's. Symposium, May 22, 7:00 p.m., Greenville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

MULTI-DISCIPLINARY/LOW BACK PAIN

For: MD's. Symposium, May 16, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

CARDIAC ARRHYTHMIAS

For: MD's. Symposium, May 23, 6:00 p.m., Jerseyville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

RHEUMATOLOGY

For: MD's. Symposium, May 31, 7:00 p.m., Benton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

EXERCISE AND THE HEART

For: MD's. Symposium, May 31, Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Medicine

OB/GYN

PERINATAL MEDICINE

For: MD's. Symposium, May 11, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 7 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Ophthalmology

OPHTHALMOLOGY CONFERENCE

For: Ophthalmologists. Lecture, May 10-11, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$140. Reg. limit: 120. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Orthopaedic Surgery

SPORTS INJURIES III

For: MD's, coaches, trainers, etc. Symposium, May 12, 9:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 5 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Otolaryngology

HEAD AND NECK ONCOLOGY

For: Surgeons, Otorhinolaryngologists. Lecture, May 14-18, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, Michigan 48109. Fee: \$400. Reg. limit: 100. Credit: AMA Category 1, 35 hours; AAFP Elective, 35 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Pediatric Anesthesia

SECOND ANNUAL PEDIATRIC ANESTHESIA MEETING

For: CRNA's, MD's, residents, nurses. Symposium/lecture, May 8-10, Chicago. Sponsor: Loyola University of Chicago, Stritch School of Medicine, Div. of CME, 2160 S. First Ave., Maywood 60153. Fee: \$170. Credit: AMA Category 1, 18 hours. Contact: Linda Gunzburger. Phone: 312-531-3236.

Pediatrics

METABOLIC PROBLEMS OF THE NEWBORN

For: MD's, nurses. Symposium, May 31, St. Louis, Missouri. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. Fee: \$60. Reg. limit: 150. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Loretta Giaconetto. Phone: 314-454-3873.

Pediatrics

SPECIALTY REVIEW IN PEDIATRIC CARDIOLOGY

For: Pediatric & Adult Cardiologists. Lecture, May 23 (3 days), Chicago. Speaker: Maria Serratto, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$175. Reg. limit: 150. Credit: AMA Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Primary Care

EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT

For: Internists, GP's. Lectures/workshops, May 11-13, Chicago. Sponsor: International Medical Education Corp., 60 Inverness Drive E., Englewood, Colorado 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 15 hours; AAFP Prescribed, 15 hours; OAO, 15 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Rheumatology

PRIMARY CARE RHEUMATOLOGY

SYMPOSIUM FOR FAMILY PHYSICIANS

For: FP's. Symposium, May 13-14, Pick-Congress Hotel, Chicago. Sponsor: University of Health Sciences/The Chicago Medical School, 2020 W. Ogden Ave., Chicago 60612. Fee: \$160. Credit: AMA Category 1, 16 hours. Contact: Janice North. Phone: 312-942-2839.

Sports Medicine

SPORTS MEDICINE—UPDATE ON CURRENT ISSUES

For: GP's. Lecture, May 9, 9:30 a.m.-5:00 p.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Surgery

CONTROVERSIES IN CARE OF SURGICAL PATIENTS

For: general surgeons. Symposium, May 16-18, Chicago. Sponsor: Dept. of Surgery University of Illinois at the Medical Center, 707 S. Wood St., Chicago 60612. Cosponsors: Warren H. Cole Society, Cook County Graduate School of Medicine. Fee: \$175; \$85 residents. Reg. limit: 350. Credit: AMA Category 1, 19 hours. Contact: Robert Baker, MD. Phone: 312-996-6765.

Trauma

FRACTURES AND OTHER TRAUMA

For: General/Orthopaedic Surgeons. Lectures/workshops, May 9-12, Radisson Hotel, Chicago. Speaker: Prof. Doctor Jorg Bohler. Sponsor: American College of Surgeons, 55 E. Erie St., Chicago 60611. Attn.: Trauma Registration. Fee: \$175; \$60, residents. Credit: AMA Category 1, 28 hours; IAFP, 28 hours. Contact: Ralph Lidge, MD. Phone: 312-392-4320.

Trauma

23rd ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA

For: GP's, Orthopaedic/general surgeons. 3½ day course, May 9-12, Radisson Chicago Hotel, Chicago. Speaker: Prof. Dr. Jorg Bohler. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 55 E. Erie St., Chicago 60611. Fee: MD's, \$185. Reg. limit: none. Credit: AMA Category 1, 28 hours; AAFP Elective, 28 hours. Contact: Ralph Lidge, MD. Phone: 312-392-4320.

JUNE

Family Therapy

WORKING WITH THE DIVORCE PROCESS

For: Psychiatrists, therapists. 1-day workshop, June 8, Chicago. Speaker: Jean Goldsmith, Ph.D. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsor: Northwestern University Medical School. Fee: \$40. Credit: AMA Category 1, 6 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-649-7285.

Family Therapy

A DAY WITH VIRGINIA SATIR

For: Psychiatrists, therapists. 1-day workshop, June 30, Hyatt Regency Hotel, Chicago. Speaker: Virginia Satir. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$40. Credit: AMA Category 1, 6 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-649-7385.

Immunohematology

MANAGEMENT OF ACUTE BLOOD LOSS

For: MD's, nurses, technologists. Lecture, June 21, 7:00-9:00 p.m., Moline. Speaker: John Collins, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., P. O. Box 70, Davenport, Iowa 52803. Fee: \$10, MD's; \$2, others. Reg. limit: 200. Credit: AMA Category 1, 2 hours; AOA, 2 hours; AAFP Prescribed, 2 hours. Contact: Pat Harrod. Phone: 319-359-5401.

Medicine

SELECTED RECENT ADVANCES IN CLINICAL MEDICINE

For: GP's. Lecture, June 14, 9:00 a.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Chicago 60637. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Medicine

NEW TRENDS IN THERAPEUTICS

For: MD's. Symposium, June 2, 1:00 p.m., Newton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Ophthalmology

OPHTHALMIC MICROSURGERY

For: Ophthalmologists. 3-day course, June 6-8, Chicago. Speaker: Jared Emery, MD. Sponsor: Dept. of Ophthalmology, Abraham Lincoln School of Medicine, University of Illinois College of Medicine, Office of Continuing Education, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: 20. Fee: \$550. Credit: AMA Category 1, 20 hours. Contact: Sue Korienek. Phone: 312-996-8025.

Pathology

CURRENT TOPICS IN BLOOD BANKING

For: Pathologists, medical technicians. Lecture, June 7-8, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Fee: \$120. Reg. limit: 500. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Primary Care

CARDIAC SYMPTOMS, ARRHYTHMIAS, AND HOLTER MONITORING

For: GP's, Internists. Lectures/workshops, June 15-17, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Dr. E., Englewood, Colorado 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Pulmonary Disease

DIAGNOSTIC & THERAPEUTIC DECISIONS IN PATIENTS WITH PULMONARY DISEASE

For: MD's. Course, June 6-8, Chicago. Sponsor: American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104. Cosponsors: Cook County Hospital; University of Illinois. Fee: varies. Reg. limit: 300. Credit: AMA Category 1, 18 hours. Contact: Linda Solsinger. Phone: 215-243-1200.

Rehabilitation

TOTAL MANAGEMENT OF THE STROKE PATIENT

For: MD's, residents, nurses. Course, June 4-8, Chicago. Sponsor: Rehabilitation Institute at Chicago, 345 E. Superior St., Chicago 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 5/15. Fee: \$200, MD; \$100, other. Reg. limit: 100. Credit: AMA Category 1, 30 hours. Contact: Don Olson. Phone: 312-649-6179.

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July

Family Therapy

FAMILY SYSTEMS ASSESSMENT (INTRODUCTORY COURSE)

For: beginning family therapists. 5-day course, July 9-13, Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Reg. limit: 24. Fee: \$155. Credit: AMA Category 1, 30 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-640-7385.

Primary Care

CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION

For: GP's, Internists. Lectures/workshops, July 27-29, Lake Geneva, Wisc. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, Colorado 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

CASSETTE RESOURCE CENTER

One-hour videocassette programs available to supplement other CME programs; most programs acceptable for credit by the AMA and AAFP; available on a rental or purchase basis to physicians/hospitals. Complete information available from: The Network for Continuing Medical Education, 15 Columbus Circle, New York, New York 10023.

RECENT CME ACCREDITATION RECOMMENDATIONS

The ISMS Committee on CME Accreditation has recommended to the Liaison Committee/CME approval of the CME programs of the following institutions:

Christ Hospital, Oak Lawn
Illinois Hospital Research & Educational Foundation

Illinois Hospital Association
Illinois Society of Allergy and Clinical Immunology

Louis A. Weiss Memorial Hospital, Chicago

Resurrection Hospital, Chicago

St. Anthony Hospital, Chicago

Sarah Bush Lincoln Health Center, Mattoon

Southern Illinois Medical Association

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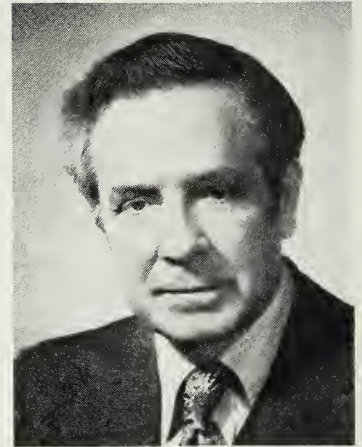
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Learning From Our Mistakes

Since the state's new Mental Health Code was implemented in January, all of its critics' worst fears have not materialized. However, the Code does contain substantial inconsistencies which have created confusion and pose problems for Illinois physicians.

Advocates hail the Code as enlightened legislation that marks Illinois as a leader in protecting the rights of mental patients. That praise largely is tied to provisions requiring that patients be read "Miranda warning"—type statements prior to admission to a mental facility. On the other hand, many psychiatrists view those provisions—and others—as admirable in concept, but totally unworkable. For example, they maintain that affording a mentally-incompetent patient the right to refuse necessary treatment creates both medical and ethical dilemmas.

While the Code was being formulated in the legislature, the medical profession voiced a wide range of diverse viewpoints. As a result, we were unable to forcefully push for concrete proposals that would improve the Code and eliminate potential problems.

Although we failed to immediately recognize the pitfalls of this ill-advised legislative approach, we quickly identified problems that would arise when the Code was implemented. This realization prompted ISMS to form a special Task Force on the Mental Health Code. The Task Force is co-sponsored by the Illinois Psychiatric Society and includes representatives from the Illinois Department of Mental Health and Developmental Disabilities and the Illinois Nurses Association. Its objective is to bring together the divergent viewpoints and formulate a unified strategy to attack the problems. The Task Force has undertaken a legal analysis of the Code and is preparing guidelines to help psychiatric facilities deal with controversial provisions. If certain requirements appear unworkable, the Task Force will propose legislative amendments.

All viewpoints are being weighed during Task Force deliberations, and differences will be resolved at that level. If we seek amendments to the Code, our legislative approach will be characterized by unity.

The problem-solving concept illustrated by the Task Force could be effectively applied to other areas. It is a sharply-focused, aggressive approach to an extremely complex law that affects all physicians—in any situation—where the primary diagnosis is psychiatric.

The advantages of internally resolving differences of opinion before entering legislative debates is obvious. The beneficiaries of this approach—exemplified by the Task Force—will be the physicians of Illinois and the public. ◀

A handwritten signature in dark ink, reading "David S. Fox". The signature is stylized, with a large, flowing "D" and "F".

David S. Fox, M.D., President

Doctor's News

UI ALUMNI REUNION ANNOUNCED—The University of Illinois College of Medicine Alumni Association have scheduled their annual reunion and awards banquet for Sunday, May 6, 1979 in Chicago. A reception at 5:00 p.m., in the New UI College of Medicine Faculty Alumni Center, (formerly the Quine Library) will be followed by a dinner in the Chicago Rooms of the Illini Union at 6:30 p.m. On Monday, May 7, a "College of Medicine Update," and tour will commence at 10:00 a.m., concluding with luncheon at noon in the Illini Union.

Reservations for Sunday's activities are \$18.50 per person, and tickets for the tour and luncheon on Monday are available for \$5.00. Checks should be made payable to the University of Illinois Alumni Association, 1737 W. Polk Street, Room 312, Chicago 60612. Additional information is available by calling (312) 996-7645.

It should be noted that the reunion coincides with the annual meeting of the ISMS House of Delegates in Chicago, May 6-9. See the annual meeting convention program on page 225 for scheduling details.

GENERIC SUBSTITUTION—The ISMS Board of Trustees has urged members to have an educational message imprinted on their prescription pads. The information, designed to ensure that patients benefit from the Illinois drug substitution law, and prevent unauthorized substitution, reads as follows:

If "may substitute" is checked, please have the pharmacist assure you that the medicine dispensed is in the Illinois Drug Substitution Formulary, and there is a cost savings to you.

The Illinois Department of Public Health has not yet officially responded to ISMS' request that the Department mandate use of a Society-developed patient consent form via regulations governing the substitution law.

ATTENTION: HEALTH EXECs—The University of Chicago has announced a new graduate program for health executives of proven management ability. An intensive, academically based program which leads to a master's degree in business administration, the course is designed for individuals in the health field with ten years' management experience. Students continue full-time employment while completing the two-year evening program. Further information is available by writing Dorothy Revelos, Executive Program, Graduate School of Business, University of Chicago, 190 E. Delaware, Chicago, IL 60611. Telephone: (312) 266-3431.

PREVENTIVE MEDICINE UPDATE—A new organization devoted to prevention of occupational respiratory disease was recently organized by representatives of four medical and one nursing association in Chicago. The Council on Occupational Respiratory Disease (CORD) was formed by the American Academy of Occupational Medicine, American Association of Occupational Health Nurses, American College of Chest Physicians, American Occupational Medical Association and the American Thoracic Society.

The Council intends to advise health professionals in preventing occupational respiratory disease and to upgrade standards of professionals in the field. Further information may be obtained by writing Mr. Howard N. Schulz, Executive Director, Council on Occupational Respiratory Disease, 150 N. Wacker Drive, Chicago 60606.

REYES SYNDROME has been the subject of research at the University of Chicago and recently released findings reported have indicated that inner-city infants appear to be particularly susceptible to the disease. According to an article in *Emergency Medicine*, by Peter R. Huttenlocker, M.D., a pediatric neurologist at the UC Wyler Children's Hospital, the disease is easily misdiagnosed as pneumonia.

Typical symptoms of Reye's syndrome include vomiting, followed by stupor and coma, as well as brain edema in many cases. The article, co-authored by Doris A. Trauner, M.D., urges physicians practicing in the inner city to make special note of infants with respiratory distress but normal x-rays. Tests for low blood sugar and high blood ammonia were further advised, and if positive, liver function tests.

PHYSICIANS IN THE NEWS—**Effie O. Ellis, M.D.**, Chicago, was recently awarded the Chicago Medical Society's 1979 Public Service Award. Dr. Ellis, co-director of the Quality of Life Center in Chicago, received the award at the annual CMS Midwest Clinical Conference. A nationally recognized expert in health and the nutritional problems of the underprivileged, Dr. Ellis is also co-chairman of the health committee of the Chicago Planning Council on Aging and Rehabilitation.

The McHenry County Medical Society elected new officers last week: **Dan Horan, M.D.**, Woodstock, president, **Ted Rolander, M.D.**, McHenry, vice president, **Stanley Chmiel, M.D.**, McHenry, secretary and **James Mowery, M.D.**, McHenry, treasurer.

Frederick D. Malkinson, M.D., Chicago, has been named editor of the AMA's specialty journal in diseases of the skin, the *Archives of Dermatology*, it was recently announced. A professor and chief of dermatology at Rush Presbyterian-St. Luke's Medical Center, Dr. Malkinson is a former University of Chicago faculty member. Northwest Community Hospital, Arlington Heights, recently announced that **Lee A. Malmed, M.D.**, a board certified radiologist and Chicago Medical School clinical associate, has been elected president of their 1979 medical staff. Other new officers at Northwest include **James J. Milford, M.D.**, vice president and **Ralph T. Lidge, M.D.**, secretary-treasurer.

Theodore R. Sherrod, M.D., Chicago, a professor of pharmacology at the UI College of Medicine in Chicago, has been appointed to serve on the National Advisory Council on Aging under the HEW National Institutes of Health. . . . **Paul Heller, M.D.**, Evanston, a professor and senior medical investigator at the UI College of Medicine in Chicago, has been appointed to the Committee to Evaluate Research Needs in Hematology by the HEW National Institutes of Health. That committee includes 11 leading U.S. hematologists.

The Chicago Society of Plastic Surgery elected a new slate of officers for 1979 at their recent annual business meeting. They are: **Stuart J.F. Landa, M.D.**, Chicago, president, **Martin C. Robson, M.D.**, Chicago, vice president, **Richard L. Sperling, M.D.**, Skokie, secretary and **Norman Hugo, M.D.**, Chicago, treasurer.

WHERE DO I GO FROM HERE DEPT.—The Governor's office has announced publication of a State of Illinois Information Directory designed to provide simple, straight forward access to state government services. The directory describes each of the 58 state agencies and contact information. It may be obtained by sending a self-addressed, stamped envelope to the Office of Inter-Agency Cooperation, Room 2010, 160 N. LaSalle, Chicago, 60601 or calling (312) 793-2754.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BUNKER HILL: Rural community, trade area 3000. Doctor retiring. Living quarters and office space available. Excellent schools and churches. Fifty miles, north-east of St. Louis, Mo. Financial assistance available if necessary. Contact: Sally Bruckert, RR #1 Box 488, Bunker Hill 62014, 618-585-3192. (7)

ELDORADO: Busy six-doctor practice looking for G.P./F.P., General Surgeon and Ophthalmologist. \$36,000 guaranteed first year. Located in town of 5000 in scenic southern Illinois. Call Dr. Elliott O. Partridge or Dr. Denton B. Ferrell, (618) 273-3361. (7)

FAIRFIELD: Need one family practitioner and one Gyn-OB man for an established two men (F.P. & Gen. Surgeon) practice in a 6500 population community. Drawing area 20,000. Excellent salary and fringe benefits. Very well equipped hospital. Excellent local schools and junior college. University 75 miles. Good recreational facilities and churches. Contact S. W. Konarski, M.D., 101 East Center Street, Fairfield, 618-842-2187. (7)

ILLINOIS: The Illinois Dept. of Corrections has immediate openings statewide for Family Practice or General Practice Physicians interested in ambulatory care. For additional information and salary schedule contact: Cecil Patmon, 160 N. LaSalle, Chicago, 60601, 312/793-3216. (6)

JACKSONVILLE: Opportunities for family practice emergency room, dermatology, OB/GYN, orthopedic surgery. Progressive 250 bed hospital, 40-member medical staff. Prosperous community with primary service area of 60,000, two colleges, excellent schools, 35 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Area Hospital, Jacksonville, 62650 (217) 245-9541. (6)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity in solo or group practice. Contact: Carol Nafziger, Minier 61759. (309) 392-2345 or 392-2120. (6)

MUNSTER, IN.: Family, ENT, Ortho.; for large mid-west multi-specialty group. Competitive first year salary with opportunity for early partnership. No investment. Most liberal vacation and P-G allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop own practice. Send C-V to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321 (219) 836-5800. (6)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensa-

tion negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

PEORIA: Orthopedic Surgeon needed in multi-specialty clinic of 12 physicians. Excellent opportunity for the right person. Located in community of 250,000, three hospitals, school of medicine. Guaranteed first year salary plus complete fringe package. Contact: Dr. R. Martin, The Medical and Surgical Clinic, S.C. 100 N.E. Randolph, Peoria, 61606. (6)

PIKE COUNTY: Population 19,000. Two general practitioners, one general surgeon, office space available beside 82 bed, JCAH, full service hospital. Financial assistance available. Ten physicians at present. Great hunting. Gary Deer, Administrator, Illini Community Hospital, 640 West Washington, Pittsfield, AC(217) 285-2113. (6)

PITTSFIELD: Family Practitioner/General Practitioner/General Surgeon to join established practice or solo. Minimum guarantee, office space available free. 82 bed JCAH full service hospital. Great bird/duck hunting. Contact Gary Deer, Illini Community Hospital, 640 W. Washington Street, Pittsfield 62363; (217-285-2113.) (7)

SOUTHERN ILLINOIS: Opening in newly remodeled community Health Services Center located in Cairo adjacent to hospital. Target population 20,000. Six physicians, two dentists, counseling services, and outpatient lab at present. Financial assistance available. Near university and colleges. Wide range of recreational facilities. CONTACT: Steve Miller, 529 Cross St., Cairo 62914 (618) 734-4200 (8)

STERLING/ROCK FALLS: Primary Care physicians needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

VALMEYER: Population 1000 with patient population of 3-4000. Scenic town on small lake. 25 miles from Belleville or Red Bud, 35 miles from St. Louis, Mo. Only physician is about to retire. Fully equipped 4 room office building for rent. Contact: H. A. Reichel, M.D., 206 W. Main, Valmeyer, IL 62295. (618) 935-2216. (6)

VANDALIA: County Hospital, serving population 25,000. Seven physicians at present. Sixty miles east of St. Louis on Interstate Highway I-70. Office space available on hospital campus. Financial assistance and deferred compensation agreements available. Contact John R. Leckrone, Administrator, Fayette County Hospital, 7th & Taylor, Vandalia 62471. (618) 283-1231. (7)

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Potassium-Sparing DYAZIDE[®]

Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense

In Edema

The triamterene in 'Dyazide' limits potassium loss and provides an additive diuretic effect to that of the hydrochlorothiazide component.

In Hypertension

As the hydrochlorothiazide in 'Dyazide' lowers blood pressure, the triamterene component limits potassium loss.

Serum K⁺ and BUN should be checked periodically

particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).



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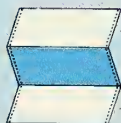
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Viewbox

(Continued from page 210)

DIAGNOSIS: Vesicovaginal Fistula -

A vertical collection of contrast with a bulbous superior end overlies and extends below the bladder. This vaginal opacification is due to a vesicovaginal fistula.

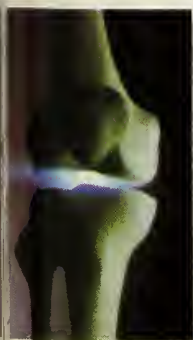
Opacification of the vagina is infrequent with an IVP in this condition. The IVP is usually normal. Dilation of the ureters and calices plus medical deviation of the distal ureters may occur secondary to ureteral stenosis or reflux caused by fibrosis in the region of the fistula.¹ Vaginograms have identified fistulas but are usually confined to infants with congenital fistulas. In the adult, dye studies and cystoscopy are the primary exams. Dye introduced into the bladder appearing on a vaginal sponge proves the diagnosis. Cystoscopy almost always locates the fistulous opening.²

These patients may present with symptoms of cystitis for days (after childbirth or surgery) to weeks or months (after radiation) before becoming incontinent as the fistula is established. Vaginal and perineal inflammation then occur.²

Vesicovaginal fistula is the most common urinary tract fistula in the female. Most frequent causes are: (1) Gynecologic surgery—usually abdominal hysterectomy; (2) Radiation therapy—usually for cervical carcinoma; (3) Advanced pelvic malignancy; and (4) Obstetric trauma—usually prolonged labor with the bladder compressed between the pubis and fetal head.³

References

1. Lagundoye, S.B., Bell, D., Gill, G., Ogunbode, O.: "Urinary Tract Changes in Obstetric Vesico-Vaginal Fistulae," *Clin. Radiol.* 27:531, 1976.
2. Campbell, M.F., Harrison, J.H.: *UROLOGY*, W.B. Sanders, Philadelphia, 1970.
3. Witten, D.M., Myers, G.H., Utz, D.C.: *CLINICAL UROGRAPHY*, W. B. Sanders Philadelphia, 1977.



Motrin[®] 400 mg TABLETS ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

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one more reason to prescribe

Motrin 400 mg TABLETS

ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)

Bottles of 60 NDC 0009-0733-01

Bottles of 500 NDC 0009-0733-02

Motrin Tablets, 400 mg (orange)

Bottles of 60 NDC 0009-0750-01

Bottles of 500 NDC 0009-0750-02

Unit-dose package of 100 NDC 0009-0750-06

Unit of Use bottles of 120 NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

EKG

(Continued from page 201)

Answers 1. A. C. 2. E.

The ECG shows sinus tachycardia at a rate of 140 beats/minute. There are deep QR patterns seen in leads V₃, V₄, and V₅ accompanied by ST segment elevation. This makes a diagnosis of acute anterior myocardial infarction. Modern treatment for an acute myocardial infarction takes place in a coronary care unit. Here appropriate monitoring and care can detect and treat any cardiac arrhythmias or shock that may develop in the early period. Our patient was hypotensive with a sinus tachycardia, a loud atrial gallop and bibasilar rales in the lungs. These findings are compatible with mild congestive heart failure and low cardiac output. Hemodynamic bedside pressure monitoring with a Swan-Ganz catheter would certainly be helpful. The presence of high left ventricular filling pressures (the pulmonary capillary wedge pressure) associated with a low systemic arterial pressure measured in a radial artery carries an ominous prognosis. Digitalis and diuretics were administered without much effect. Later, our patient did develop the full clinical syndrome of cardiogenic shock and was treated with the intra-aortic balloon pump. Use of counterpulsation helped support our patient and he survived. For further reading, see S. A. Johnson, *et al.*, *American Journal of Medicine*, 62:687-692, 1977.

1979

ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for 1979:

May 19-June 1—Adriatic/Greek Isles Cruise
(Venice-Dubrovnik-Athens)

June 24-July 5—Rhine Cruise (Munich, Rhine
River, Brussels)

July 30-Aug. 12—European Adventure (Paris,
Interlaken, Florence)

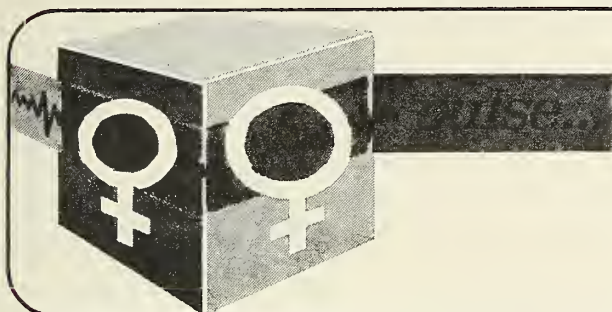
Sept. 2-15—Danube Cruise (Vienna to Istanbul)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

NIM-3



The Upjohn Company
Kalamazoo, Michigan 49001



of the ISMS auxiliary

MRS. EUGENE VICKERY, Editor

Growth Patterns

District VIII Reports

District VIII has organized medical auxiliaries in Vermilion, Coles-Cumberland, and Champaign counties. Members-at-large are welcomed from all the other unorganized counties.

The organized auxiliaries are not only growing, but thriving. The dedication of older members is enhanced by the enthusiasm of newer ones, and by a resurgence of interest in the auxiliary.

Coles-Cumberland Auxiliary reorganized in June, 1978, with Mrs. Mack W. Hollowell as president. They have already prepared a brochure to be included with the hospital information kit which is given to new physicians being recruited in the area.

Vermilion County was organized in 1928 and has full support of the medical community with 100% membership. Their accomplishments are impressive with a constant goal of AMA-ERF support. Speakers have included one on the Impaired Physician, another on 'Cults' by a de-programmed Moonie, and one on Legislation by Mrs. Alan Taylor of IMPAC. The Ethnic Dinner in March for auxiliaries and spouses featured International Health with speakers from Australia, England and Ireland. Auxiliaries also presented a puppet show on Food and Nutrition at various schools. Currently Vermilion County Auxiliary has researched the need for hospices and are in the planning stages of starting one. Past-president Mrs. Jaime L. Gomez is now a Director on the State Board and Mrs. Grover Seitzinger has been nominated to the State Board as District VIII Councilor. Epitomizing the auxiliaries' dedication is their president, Mrs. Malcolm Spencer, who, despite moving to Veedersburg, Indiana, is completing her term of office.

Champaign County Auxiliary, having been formed in 1950, may be the 'baby' of District VIII, but it's a lusty infant nonetheless. Programs on the Impaired Physician and on Legislation were well received. Their program on 'Cults' by an ex-Moonie has engendered interest in having a "de-programmer" as a speaker. The sale of Christmas cards boosted AMA-ERF contributions.

Champaign Auxiliaries decided they would concentrate on the full-funding of a nursing scholarship to Parkland Junior College. The first scholarship benefit, a picnic-dance, was held last fall. From 31 applicants, the scholarship committee chose a mature woman whose family obligations made it seem likely that she would remain in the community. Four deserving students also were given \$25 book stipends. To further support the scholarship fund, past president Mrs. Jack Brodsky, conducted two vegetable carving courses. It is hoped that proceeds from a giant rummage sale on April 6 at the Urbana Civic Center will enable the auxiliary to offer two full scholarships next fall.

Mrs. Milton Carlson is president of the Champaign Auxiliary. Mrs. James Laidlaw is ending her term as councilor. Mrs. Harlan Failor serves on the State Board as 1st Vice President and membership chairman of ISMSA.

It is members like these in District VIII who carry out the auxiliary pledge, "I pledge my loyalty and devotion to the American Medical Association Auxiliary. I will support its activities, protect its reputation and ever sustain its high ideals."

—Mrs. James Laidlaw, Councilor
District VIII

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Illinois Medical Journal

(USPS 258-160)

MAY, 1979

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of in-

Increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.
Precautions: If combined with other (psycho)otics or anticonvulsants, consider carefully pharmacology of agents employed. Drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Abstracts of Board Actions

March 31-April 1, 1979

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

LEGAL ACTION

In actions involving litigation, the Board voted to:

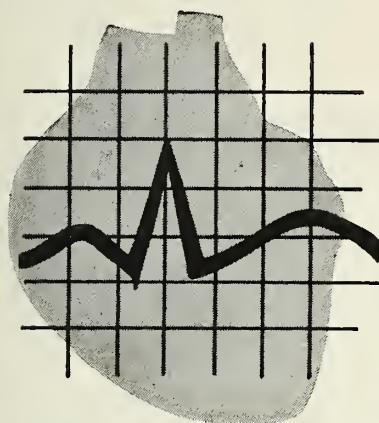
- Support the petition to the U.S. Supreme Court for certiorari in the "malpractice" countersuit of Dr. Leonard Berlin, Skokie. An appellate court reversed Dr. Berlin's lower court victory, and the Ill. Supreme Court refused to review the case. In his petition, Dr. Berlin will contend that his constitutional rights will be violated if he is denied a review by the Supreme Court. The countersuit charges the patient and her attorneys with "recklessly and willfully" filing a non-meritorious suit. A favorable Supreme Court ruling would "break new legal ground" in countersuits.
- File an amicus curiae brief—echoing a similar Ill. Hospital Assn. brief—with the Ill. Supreme Court in a case involving the constitutionality of the statute of limitations for malpractice claims. In the case—*Woodard vs. Burnham City Hospital, Champaign*—an appellate court ruled that the statute was unconstitutional because it constituted special legislation. However, the statute's constitutionality was upheld by another appellate court in a similar suit. The statute prohibits the filing of a malpractice suit more than two years after discovery and—in no event—more than four years after occurrence. For minors, the statute does not take effect until the patient's 18th birthday.
- File an amicus curiae brief with the Ill. Supreme Court in a case which challenges a statute protecting persons who testify before in-hospital staff committees. The brief—aimed at protecting the statute which ISMS fought to enact—will support the appeal of an Illinois appellate court decision which limited immunity and threatened to jeopardize peer review activities.

LEGISLATION

The Society will seek legislation in the current General Assembly session to:

- Establish a legislative commission to study the need for a catastrophic health plan in Illinois, along with an appropriate funding mechanism for such a program. Meanwhile, ISMS will study the feasibility of seeking "circuit breaker type" legislation designed to offset catastrophic illness expenditures. The bill would feature uniform benefits, tax rebates or cash grants for the payout, and risk-pooling and premium taxes for funding.
- Amend the state's Mental Health Code to: (1) Allow use of clinical judgment to determine when a patient may be informed of his legal rights without aggravating his mental condition; and (2) Facilitate immediate treatment—despite parental objections—of minors needing emergency psychiatric care. ISMS also may seek at a later date amendments that would: (1) Require a patient's expressed consent before guardians and others can be notified that

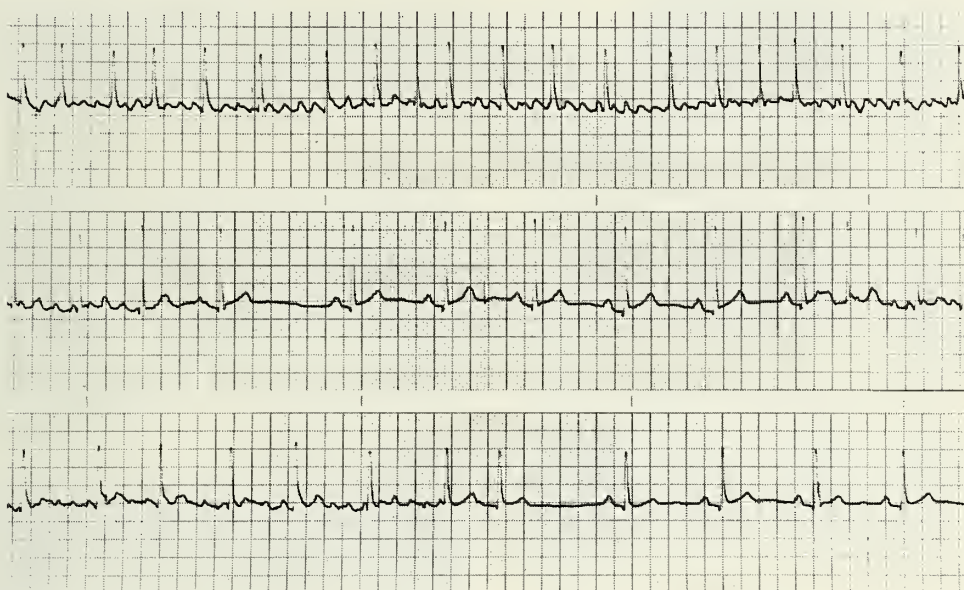
(Continued on page 321)



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A sixty-year-old man had been hospitalized for an acute myocardial infarction with congestive heart failure and frequent premature atrial beats. He had been digitalized and recovered. He was discharged from the hospital after three weeks. In his first post-hospital office visit, he complained of intermittent palpitations. The palpitations were not predictable nor were they associated with chest pain or other discomforts. His physical exam was negative except for an occasional premature beat and an atrial gallop. A twenty-four-hour ambulatory ECG tape recording (Holter) was made. The rhythm strip shown was recorded during an episode of palpitations.



Questions:

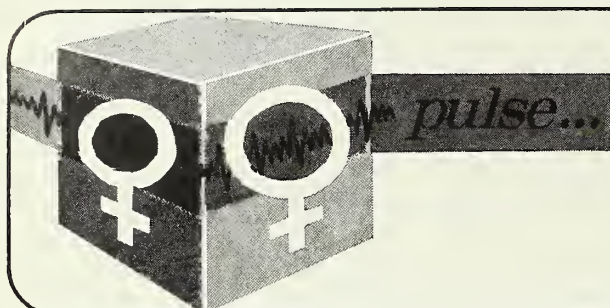
1. The rhythm strip shows:

- A. Paroxysmal atrial flutter with variable AV block.
- B. Paroxysmal atrial fibrillation.
- C. Paroxysmal atrial tachycardia with variable AV block.
- D. Junctional tachycardia.
- E. None of the above.

2. Treatment of this problem might include:

- A. An increased dose of digitalis intravenously.
- B. Oral quinidine.
- C. Direct current cardioversion.
- D. Reassurance of the patient only.
- E. All of the above.

(Continued on page 344)



of the ISMS auxiliary

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DISTRICT XII REPORTS

MRS. JOHN LEONARD, COUNCILOR

Organized Counties:

DeKalb County—May 4, 1949—50 members

Ogle County—March 4, 1975—9 members

Stephenson County—Sept. 22, 1953—49 members

Winnebago County—May 14, 1951—219 members

Photo caption (left to right):

Mrs. R. S. Hoover (Sheila), newly installed president of the Illinois State Medical Society Auxiliary and Mrs. John Leonard (Martha), District XII Councilor from Rockford.

District XII auxiliaries are working to assist their medical societies in their programs to improve the quality of life through health education and services, and also cultivate friendly relations and promote mutual understanding among physicians' families.

Ogle, our newest auxiliary, continues to be active AMA-ERF fund raisers and last year won a regional first place at national convention for their efforts. Ogle Auxiliary co-sponsored a community luncheon and program about the Hospice concept along with other AMA-ERF fund raising events during the year.

Stephenson County has celebrated 25 years as an active auxiliary. New this year was a fall newsletter to inform members and prospective members of the history, details and projects of the medical auxiliary. Their Christmas sharing card added over \$650 for AMA-ERF plus a progressive dinner netted nearly \$700 for scholarships and AMA-ERF. An auction added \$300 to the state Benevolence Fund.

Winnebago County has a monthly newsletter, *The Acquainter*. The general membership is not only encouraged but urged to attend the monthly

board meetings. \$3,425 has been raised for the AMA-ERF Fund and their "Charisma '78" netted \$4500 in scholarships. The Auxiliary updated their Health Career slide presentation for high schools and took it to all schools from November through March. The auxiliary is indirectly involved in the Rockford area program for the International Year of the Child with emphasis being placed largely on immunization and nutrition.



District 12 Left to right: Teresa Tisovec, Winnebago Pres. 1978-79; Camille Descourouez—Stephenson Pres. 1978-79; Esther Lopez—Past Pres. Stephenson Co.; Cathryn Johnson—Winnebago (past state corresponding sect); Sheila Hoover—new President of ISMSA; Phyllis Nathan—Winnebago President 1979-80.



News Update

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Gearing Up Now For July National RPS Meeting

The AMA will hold its 1979 Annual Meeting in Chicago on July 22-26. After much debate, the RPS has chosen to also hold its Annual Meeting in July on the day preceding the AMA meeting (July 21). The change from June to July obviously poses difficulties for residents, as July is the first month of the residency year and many residents have difficulty in arranging time off in July. By changing the start of the meeting from Friday morning to Friday Night, it is hoped that residents can more easily arrange to come in on Friday night for the meeting.

In addition to the usual business meeting, this July meeting will have programs on National Health Insurance and Positive Health Care Strategies, as well as luncheon speakers on topics of interest. Illinois as the host state will again have a cocktail reception for the other RPS members as well as all members of the Illinois delegation.

As of this printing, an Illinois resident, Dr. Ira Isaacson (currently Chairman of the Illinois RPS) is planning to run for a Governing Council position on the AMA-RPS. It is important that Illinois have full resident representation at the July 21st meeting to support Dr. Isaacson's candidacy. Please set aside the date and contact the AMA Department of Housestaff Affairs for details of the meeting.

..... And for Hawaii in December

The AMA will hold its 1979 Interim Meeting in Honolulu on Dec. 2-5. The RPS Interim Meeting will be on Dec. 1 in Honolulu. With the most recent Chicago winter in mind, Hawaii seems an ideal place to vacation in December; if vacation plans can work around attending the RPS meeting, so much the better! Keep the RPS in mind as you negotiate your schedule for 1979-80, and you, too, could enjoy a Christmas suntan.

RPS Trustee Consultant Named

Jere Friedheim, M.D., will serve as the ISMS-RPS consultant from the ISMS Board of Trus-

tees. Dr. Friedheim met with the Governing Council both at its Feb. 7th and Mar. 7th meetings and provided welcome input from the Board of Trustees. The RPS Governing Council welcomes his presence and hope that his attendance at RPS meetings will provide a valuable flow of information between the Board of Trustees and the Resident Physicians Section.

Leaders Moving On

One of the sad times for the RPS comes each July as people who have been active with the organization move onward into practice or to fellowships in different geographic areas. The 1978-79 RPS will in particular feel the loss of Drs. Ira Isaacson and James Debord, both of whom have contributed an enormous amount to the Illinois RPS.

Dr. Isaacson, the current RPS President, finishes his Anesthesiology residency at Northwestern University this June and will be doing a fellowship at Harvard Medical School next year. Ira will be remembered for his able leadership and eloquent support of resident-sponsored bills on the floor of the ISMS House of Delegates.

Dr. Debord has represented the ISMS-RPS as a delegate to the ISMS House of Delegates. In addition, he has represented all residents on the AMA Council on Scientific Affairs. Jim's ability to devote large amounts of time to the RPS while at the same time filling the harried schedule of a senior surgical resident is much appreciated. He plans to go into practice in Peoria, and we hope will maintain his interest in the State Society there.

For all of the residents who are leaving their residency and starting practice, we wish you the best of luck. We sincerely hope that you found an advantage in belonging to the State Medical Society and that you will join the local society wherever you are in practice. If the State Societies and the AMA are to be viable modern organizations, they must attract the young physicians in practice—and only you can make this possible. ◀

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Warnings: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Usage in Pregnancy: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore, use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

Precautions: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

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Dosage and Administration: **Adults:** Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to

reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg./ml., but not to exceed 20 mcg./ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg. per kg. per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

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IMJ

Illinois Medical Journal

Vol. 155, No. 5, May, 1979

Cellulitis Of The Face Caused By *Hemophilus Influenzae* During Childhood

DANIEL G. CUNNINGHAM, M.D., AND MARK S. PUCZYNSKI, M.D./MAYWOOD

Hemophilus Influenza is frequently encountered as a serious pathogen during childhood, especially in the preschool years. Infections caused by this organism are frequently serious and life threatening in the form of meningitis, septicemia, epiglottitis, upper and lower respiratory infections, arthritis and osteomyelitis.¹ Cellulitis, especially of the face, occurring in this age group is now being recognized as another clinical entity in which *Hemophilus Influenzae* is the leading causative organism.

The purpose of this article is to present two cases of cellulitis of the face caused by *Hemophilus Influenzae* illustrating the clinical manifestations, complications and management of the disease.

Case I

A seven-month-old white male was admitted to the hospital with a history of fever of 24 hours duration and swelling of the left cheek. On admission his temperature was 39.5C. He was irritable and appeared septic. The left eardrum was dull and bulging. The left cheek was swollen and erythematous with a central tender, indurated

mass measuring four centimeters in diameter, exhibiting a small area of bluish discoloration. No other abnormalities were found on physical examination. An aspirate from the inflamed area revealed no organism on gram stain. The leukocyte count was 21,000, neutrophils predominating. Cultures were taken of the throat, blood and aspirate and ampicillin therapy was begun intravenously. Blood and aspirate cultures grew *Hemophilus Influenzae* type B, Beta lactamase negative. A full course of ampicillin was given and the lesion healed uneventfully without local or systemic complications.

Case II

A six-month-old male presented because of fever. Temperature was 39C, rectally. The left eardrum was bulging and the patient was treated with Amoxacillin. Within 24 hours he developed

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swelling of the left cheek with a central tender, indurated, bluish red mass five centimeters in diameter. An aspirate from the area revealed gram negative rods. WBC count was 20,000, neutrophils predominating. CSF was normal. Ampicillin and chloramphenicol were administered intravenously and the temperature returned to normal within 24 hours. Cultures of the blood and aspirate grew *Hemophilus Influenzae*, type B, beta lactamase positive. Chloramphenicol was continued alone. After 10 days of treatment an abscess remained from which 4cc of pus was evacuated. Following aspiration, the lesion healed rapidly and the patient made a complete recovery.

Discussion

Each case illustrates the typical clinical features of *Hemophilus Influenzae* cellulitis. Both were young children with rapid onset of symptoms and localization of the lesion to the face with an overlying bluish discoloration. High fever, leukocytosis and positive cultures from blood and local aspirate were common to both cases. All of these features are encountered in most cases of *Hemophilus Influenzae* cellulitis.²

The second case is of particular interest in that the organism was ampicillin resistant. Because of this and the association of septicemia with *Hemophilus Influenzae* cellulitis¹⁻³ it is recommended that all patients be treated with both ampicillin and chloramphenicol until antibiotic sensitivity tests have been performed.

The importance of aspiration of the lesion is illustrated by the fact that culture of the aspirate was positive in both cases and gram stain was positive in one case. Gram stain was helpful in excluding gram positive infection. Cultures of blood and local aspirate are recommended in all cases and spinal fluid examination should also be considered.^{2,4} ◀

References

1. Todd, J.K., Bruhn, F.W.: "Severe *Hemophilus Influenzae* Infections," *Am. J. Dis. Child.*, 129:607-611, 1975.
2. Smith, D.H.: "*Hemophilus Influenzae* Cellulitis," *Am. J. Dis. Child.*, 130:1193-1194, 1976.
3. Rapkin, R.H., Bautista, G.: "*Hemophilus Influenzae* Cellulitis," *Am. J. Dis. Child.*, 124:540-542, 1972.
4. Nelson, J.D., Ginsburg, C.M.: "An Hypothesis on the Pathogenesis of *Hemophilus Influenzae* Clinical Cellulitis," *J. Pediatr.*, 88:709-710.

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular

basis, and urges Illinois physicians to notify their patients of this service.

June 5	Daley Center	Chicago
July 8	Seventh Day Adventist Church	Hinsdale
July 30	Lutheran General Hospital	Park Ridge
August 6	YWCA	Rockford
September 9	Seventh Day Adventist Church	Hinsdale
September 10	Christ Hospital	Oak Lawn
September 17	St. Therese Hospital	Waukegan
October 8	Lake Forest Hospital	Lake Forest
October 29	Lutheran General Hospital	Park Ridge
November 5	YWCA	Rockford
November 5	Christ Hospital	Oak Lawn
November 11	Seventh Day Adventist Church	Hinsdale

Factors Influencing Practice Location

Illinois' Non-Urban Primary Care Physicians

By LOLA JEAN SHATTUCK, M.A., GABRIELLE D'ELIA, M.A., AND
J. ROLAND FOLSE, M.D./SPRINGFIELD

Presented before the North American Primary Care Research Group at Williamsburg, Virginia on March 26, 1977.

Knowledge of the factors influencing physicians to select and remain in rural area practice is essential. The data from this study conducted in 16 southern Illinois counties demonstrate various reasons why physicians selected a given area for practice. Both well-established and newly-recruited physicians gave preference for a rural lifestyle as reason for setting up a practice in southern Illinois. This study also suggests that communities without existing physicians and hospitals may have difficulty recruiting a new physician.

National concern over rural health care is reflected by the many incentives that have evolved to entice physicians to choose a rural practice location. For example, medical societies or communities sponsor "Doctors' Job Fairs" where physicians can learn about practice opportunities. A community may offer special financial inducements to physicians who set up a practice, a student loan program may require service as repayment, and a medical school may give admission preference to students from rural areas. The results of efforts to attract physicians to rural areas are greatly affected by various factors which in-

fluence physicians' decisions about practice site selection.

Southern Illinois University School of Medicine is a community-based medical school with a legislative mandate to be responsive to health care needs of the people in central and southern Illinois, a 52-county, predominantly nonurban area. The identification of factors which will attract and retain physicians in central and southern Illinois is important for the development of programs. Knowing what factors influenced physicians to select a practice site in central and southern Illinois is one method for assisting in the development of these programs.

Methodology

A multimethod approach was developed with eight survey instruments designed to gather data from various sources. One of the instruments was a self-administered questionnaire which solicited information about factors which influenced the physician in his selection of a practice location. A list of 26 factors, similar to those developed by Coleman,¹ was constructed. The factors included personal, family, economic, geographic, cultural, social, and professional considerations. The physician was asked to select from the list of factors those which influenced his decision about locating his office practice. A second question asked

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Table 1
Factors Selected by Physicians
as Influencing Their Decision about Practice Location
 N = 30 physicians

	Number of physicians selecting each factor	Percent of physicians selecting each factor
1. Preference for urban or rural living	21	70.0
2. High medical need in area	18	60.0
3. Income potential	17	56.6
4. Availability of clinical support facilities and personnel	16	53.3
5. Opportunity to join desirable partnership or group practice	14	46.6
6. Quality of educational system for children	14	46.6
7. Climate or geographic features of area	12	40.0
8. Raised in a similar community	11	36.6
9. Influence of spouse (his/her desires, career, etc.)	8	26.6
10. Opportunity for regular contact with other physicians	8	26.6
11. Recreational and sport facilities	7	23.3
12. Influence of family or friends	6	20.0
13. Organized efforts of community to recruit physicians	6	20.0
14. Advice of older physician	5	16.6
15. Opportunities for social life	5	16.6
16. Prosperity of community	5	16.6
17. Access to continuing education	4	13.3
18. Potential for becoming involved in community affairs	4	13.3
19. Availability of good social service, welfare or home care service	3	10.0
20. Opportunity for regular contact with a medical school or medical center	3	10.0
21. Cultural advantages	3	10.0
22. Attended medical school, internship, residency, military service near here	3	10.0
23. Opportunity to work with specific institution	2	6.6
24. Availability of loan for beginning practice	1	3.3
25. Payment of "forgiveness loan"	0	0.0
26. Influence of preceptorship	0	0.0

Number of Responses: 194

that the physician select from the list of 26, three factors which had the greatest influence on his practice location decision and rank them in order of importance.

Sample

A 16-county geographical area was selected which had a physician population of 235 in active practice. The mean age of the 235 physicians was 51.8 with an overall median age of 50. The target population was general/family practitioners and general surgeons who were 65 years of age or younger in active practice. (For the purposes of this paper, the term "family practice," will describe physicians who listed their specialty as general practice or as family practice.) Since the purpose of this study was to obtain an in-depth picture of how medicine is practiced in central and southern Illinois, a proportional stratified sampling method was used. This produced a sample of 37 physicians who, when com-

pared in terms of age, specialty, location and office practice arrangement, did not differ significantly from the population. Of the 37 physicians, 30 completed the self-administered questionnaires. These included ten family practitioners and six general surgeons in solo practice as well as nine family practitioners and five general surgeons in some type of group office practice.

Results

An analysis of the survey findings is presented in three sections: 1) a discussion of the factors which each physician indicated had some influence on his practice location decision and a discussion of the three factors which each physician reported had the greatest influence on his practice location decision; 2) a discussion of the relationship between the number of years the physician had been in practice in the community and the three factors he ranked as most important; and 3) a discussion of the relationship be-

Table 2
Physicians Ranking of Factors as 1st, 2nd, 3rd
In Importance To Their Decision about Practice Location

N = 30 physicians

	Number of physicians ranking factors 1st, 2nd or 3rd as influential			Total
	1st	2nd	3rd	
1. Preference for rural living	4	5	4	13
2. High medical need	6	4	2	12
3. Raised in a similar community	5*	3	2	10
4. Income potential	4	3	2	9
5. Opportunity to join desirable partnership or group practice	3	1	5	9
6. Availability of clinical support facilities and personnel	2	4	3	9
7. Influence of family or friends	3	1†	1†	5
8. Quality of educational system for children	1	1	2	4
9. Climate or geographic features of area		2	2	4
10. Influence of spouse		1	1	2
11. Access to continuing education		1	1	2
12. Prosperity of community		2		2
13. Recreational and sports facilities			1	1
14. Opportunities to work with specific institution	1			1
15. Organized efforts of community to recruit physicians		1		1
16. Advice of older physician			1	1
17. Other*	1			1
Total	30	29	27	

*Two physicians wrote in that they were practicing in their "home town" or were raised in the community.

**One physician wrote "potential to do what I've been trained to do."

†One physician checked this factor for all three choices.

Note: One physician did not make a second ranking choice, and three physicians did not make a third ranking choice.

tween the physician's specialty and type of office practice and the three factors he ranked as most important.

Factors Important for Location

From the list of 26 items presented in Table 1, physicians were asked to indicate which factors had influenced them in their choice of practice location. The factor "preference for rural living" was selected most frequently, and was cited as an influence by twenty-one (70%).

The second most often selected factor was "high medical need in area." Sixty percent of the physicians chose this factor. Fifty-seven percent of the respondents selected "income potential." Other factors selected by more than 40% of the physicians include "availability of clinical support facilities and personnel," (53%); "opportunity to join desirable partnership or group practice," (47%); "quality of the educational system" (47%); and "climate or geographic features of the area," (40%). Eleven (37%) of the physicians selected the factor "raised in a similar community." Sixteen of the remaining factors

were selected by a quarter or fewer of the physicians. Two factors, "payment of forgiveness loan" and "influence of preceptorship program" were not selected.

Ranking of the Factors

In addition to indicating which factors from the 26-item list had some influence on his practice location selection, the physician was asked to select the three factors which had the greatest influence on his decision and to rank these from one to three in the order of their importance. As Table 2 illustrates, seventeen of the 26 factors were selected when this ranking procedure was used, however, only six of the factors were chosen with frequency. Eight of the factors were given some ranking by only one or two of the physicians.

Using the ranking technique, physicians identified as most important basically the same factors which they selected most frequently from the total list as having any influence. "Preference for rural living," "high medical need," "raised in a similar community," "income potential," "opportunity to join a desirable partnership or

Table 3
The 17 Factors which were Ranked 1st, 2nd and 3rd by the Physicians
As Important Influences in Their Decision about Practice Location
As Compared to the Number of Years in Practice in the Current Community
 N = 30 physicians

Factors influencing the physician in his selection of a practice location	Number of Years physicians in practice				Total number of responses
	1-5	6-10	11-20	20-35	
1. Preference for rural living	2	4	1	6	13
2. High medical need in area	3	3	2	4	12
3. Raised in a similar community	1	2	3	5	11
4. Income potential	2	2	1	4	9
5. Opportunity to join desirable partnership or group practice	3	1	1	4	9
6. Availability of clinical support facilities and personnel	3	1		5	9
7. Influence of family or friends		3	1	1	5
8. Quality of education system for children	1	1	1	2	5
9. Climate or geographical features of area	2	1	1	1	5
10. Influence of spouse	1		1	1	3
11. Access to continuing education	1		1		2
12. Prosperity of community	1			1	2
13. Recreation and sport facilities				1	1
14. Opportunity to work with specific institution			1		1
15. Organized efforts of community to recruit physicians	1				1
16. Advice of older physician			1		1
17. Other*		1			1
Responses Totals	21	18	15	35	90
Number of Physicians	7	6	5	12	

*One physician wrote in "potential to do what I've been trained to do."

group," and "availability of clinical support" were the most frequently ranked variables. However, when the ranking procedure was used, the factors "quality of educational system" and "climate or geographic features" appeared less influential in the physicians' decision making process.

Number of Years in Practice in the Current Community

The physician was asked how long he had been in practice in the current community. The responses ranged from one year to 35 years. Of the 30 physicians, seven (23%) stated they had located in the community as recently as five years ago. Six physicians (20%) had located in the community 6-10 years ago. Five physicians (17%) had been in the community from 11-20 years and the remaining twelve (40%) had been in the community for more than 20 years.

Table 3 presents the comparison of the physicians' years in practice in the current community and the 17 factors which the physicians ranked as either first, second or third influences in their decision about a practice location. Few differ-

ences are demonstrated between the physicians who had made a practice location decision recently and the physicians who had made the same decision 20 years ago or more, except that fewer of the new physicians reported that having been "raised in a similar community" was an influence. Only three of 13 physicians (23%) who entered practice in the community in the last ten years as compared to eight of 17 physicians (47%) who have been in practice 11 years or more ranked the factor "raised in a similar community" as an important influence. Independent differences also accounted for a variety of isolated selections.

In general, however, the factors "preference for rural living," "high medical need" and "income potential" along with the clinical factors, "opportunity to join a group" and "available clinical support" were most frequently selected, regardless of length of practice.

Practice Arrangement and the Physician's Specialty

The physician was asked to indicate his special-

Table 4
The 17 Factors which were Ranked 1st, 2nd and 3rd by the
Physicians as Important Influences in Their Decision about Practice
Location as Compared to Their Specialty and Practice Arrangement

N = 30 physicians

Factors influencing the physician in his selection of a practice location	Type of specialty and practice arrangement				Total number of responses
	General Practitioner		General Surgeon		
	Solo	Group	Solo	Group	
1. Preference for rural living	6	3	1	3	13
2. High medical need in area	4	4	3	1	12
3. Raised in a similar community	4	5	1	1	11
4. Income potential	2	2	3	2	9
5. Opportunity to join desirable partnership or group practice	2	3	1	3	9
6. Availability of clinical support facilities and personnel	4	1	2	2	9
7. Influence of family or friends	1	1	3		5
8. Quality of education system for children	2	2		1	5
9. Climate or geographical features of area		1	2	2	5
10. Influence of spouse	1	1	1		3
11. Access to continuing education		1	1		2
12. Prosperity of community	1	1			2
13. Recreation and sport facilities	1				1
14. Opportunity to work with specific institution		1			1
15. Organized efforts of community to recruit physicians			1		1
16. Advice of older physician		1			1
17. Other*				1	1
Response Totals	28	27	19	16	90
Number of Physicians	10	9	6	5	

*One physician wrote in "potential to do what I've been trained to do."

ty and present practice arrangement. These data were compared with the ranked factors. (See Table 4) While some differences were found when responses were separated by both specialty and practice arrangement, the small number in each category makes interpretation tentative. When comparisons were made between solo and group practitioners, regardless of specialty, the same basic factors emerged along with factors previously identified as important for establishing a successful economic and clinical practice.

When the responses of the family practitioners were compared with the responses of the general surgeons, a number of differences became apparent. The family practitioners gave the most stress to the factors "preference for rural living," "raised in a similar community," and "high medical need in the area." The surgeons selected the factor "income potential" most frequently and also rated the "rural preference" and "available clinical support" factors as highly important. Unlike the family practitioners, the surgeons were not influenced in their practice location decision by having been "raised in a similar community."

Summary and Discussion

The sample of physicians surveyed in this study identified the factors which had influenced them to set up practice in communities in a non-metropolitan area of southern Illinois. From a list of 26 factors, five or six emerged as most important. "Preference for rural living" was the most frequently selected factor, whether identified by physicians checking any of the 26 factors which influenced their practice location selection or by physicians ranking the three most important influences. In addition to having a preference for rural area, the physicians selected factors which related to the establishment of a successful practice. Economic and clinical considerations were selected together as requirements. The factors "high medical need in the area" and "income potential" were identified as important, but the physicians were not simply identifying sites where they would have a sufficient patient volume to establish a practice or a patient population with a sufficient ability to pay for services. The factors selected also indicated that nonmetropolitan practice location re-

quired sufficient clinical support, either in terms of the physicians' joining a partnership or group or having clinical facilities and personnel available in the community.

The data in this study reflect post hoc judgments by physicians about factors which influenced them when they selected their location. Whether or not the same influences affect physicians entering practice for the first time cannot be answered by this research. However, the study results are congruent with the findings of other research. The importance of income as an influence on practice location decisions has been noted in previous studies,² and while "income potential" was not the most frequently selected influence in this study nor in another study of southern Illinois physicians,³ it was one of the five most frequently selected factors.

Research has indicated that new physicians are more likely to enter and prefer group practices than solo practices,⁴ and thus opportunities for group practice should serve as a practice decision influence. Almost half the physicians in this study selected the factor "opportunity to join desirable partnership or group practice" as having had some influence on their practice decision, and it emerged as one of the five most important influences when the ranking procedure was used. In response to an additional question in this survey, over half the physicians who had entered a solo practice in the last ten years indicated they now felt a group practice would be more ideal. These findings suggest that recruitment efforts need to give strong consideration to the physicians' perception of adequate clinical support for an effective practice. In addition to group practice, the availability of clinical facilities such as hospitals has been shown to be important.⁵⁻⁷ "Availability of clinical support facilities and personnel" was one of the five most important factors identified in this study, and all but one of the respondents had selected a community with a hospital for practice.

The major finding of this study, however, is the emphasis given "preference for rural living." Other studies have demonstrated the relationship between the physician's background and his rural or urban choice.⁸⁻¹² The finding that a physician from a city is more likely to practice in a city than in a rural area¹³ has led to programs encouraging students from rural backgrounds to enter medical schools. While in this study the factor "raised in a similar community" was mentioned as an influence by one third of the physicians, the more recently recruited physicians were not likely to have come from a rural background.

The most important determinant appeared to be a preference for a rural area, a finding suggested as having an influence in other studies.^{14,15} Twenty-one (70%) of the 30 physicians in this study had some type of urban clinical experience and still chose a nonmetropolitan practice.

The major conclusion to be drawn from this study is that attracting physicians to nonmetropolitan areas requires identifying individuals who prefer a rural life style. Other factors cited as important, such as income potential and available clinical facilities, including group practices, are obviously available in urban and suburban areas also. For physicians who first have an interest in rural practice, those other factors related to the development of a successful practice then become important. This study would suggest that physician recruitment programs in communities without other physicians and hospital facilities will be expected to encounter difficulties in attracting or retaining physicians. While some of the physicians reported influence of cultural and social aspects of the community, such factors were not major determinants in their decisions.

Medical schools with responsibility to rural areas need to give emphasis to identifying students with preferences for rural practice, encourage the development of clinical resources in the area, and prepare students for rural practice. The fact that none of the physicians in this study selected the factors "influence of residency or medical school training" is a commentary on the geographic distribution of medical schools and residency programs in rural areas until relatively recently. ◀

References

1. Coleman, Sinclair: *PHYSICIAN DISTRIBUTION AND RURAL ACCESS TO MEDICAL SERVICES*, (Santa Monica: Rand, 1976) p. 63.
2. Champion, Dean J. and Olson, Donald B., "Physicians Behavior in Southern Appalachia: Some Recruitment Factors," *Journal of Health and Social Behavior*, 12:245-252, 1971.
3. McCoy, John A. and Mild, Charles F., *A PROFILE OF SOUTHERN ILLINOIS PHYSICIANS*, (Springfield: Office of Health Systems Research, Southern Illinois University School of Medicine, 1976).
4. Cooper, James K., Heald, Karen, Samuels, Michael and Coleman, Sinclair: "Rural or Urban Practice: Factors Influencing the Location Decision of Primary Care Physicians," *Inquiry*, 12:18-25, 1975.
5. Bible, Bond L. "Physicians' Views of Medical Practice in Nonmetropolitan Communities," *Public Health Reports*, 85:11-17, 1970.

6. Weiskotter, H. G., Wiggins, M. E., Gooch, Altenderfer M., and Tipner, A.: "Trends in Medical Practice: An Analysis of the Distribution and Characteristics of Medical College Graduates, 1915-1950," *Journal of Medical Education*, 35:1071-1121, 1960.
7. McCoy, *op cit*.
8. Parker, Ralph C. Jr. and Tuxhill, Thomas G.: "The Attitudes of Physicians Toward Small Community Practice," *Journal of Medical Education*, 42:327-344, 1967.
9. Bible, *op cit*.
10. Cooper, James D., Heald, Karen and Samuels, Michael, "The Decision for Rural Practice," *Journal of Medical Education*, 47:939-944, 1972.
11. Champion, *op cit*.
12. Coleman, *op cit*.
13. Parker, *op cit*.
14. Parker, *op cit*.
15. McCoy, *op cit*.

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1979

ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for 1979:

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AAP Immunization Schedules

The tables below represent the official immunization schedules for normal infants and children, as adopted by the American Academy of Pediatrics. In response to reports that the variety of immunization schedules now in use has caused some confusion, the ISMS Board of Trustees has directed that these be published as a service to the membership.

Table 1
Recommended Schedule for Active Immunization of Normal Infants and Children

2 mo	DTP ¹	TOPV ^{2a}
4 mo	DTP	TOPV
6 mo	DTP	2b
1 yr		Tuberculin Test ³
15 mo	Measles, ⁴ Rubella ⁴	Mumps ⁴
1½ yr	DTP	TOPV
4-6 yr	DTP	TOPV
14-16 yr	Td ⁵ —repeat every 10 years	

1 DTP—diphtheria and tetanus toxoids combined with pertussis vaccine.

2a TOPV—trivalent oral poliovirus vaccine. This recommendation is suitable for breast-fed as well as bottle-fed infants.

2b A third dose of TOPV is optional but may be given in areas of high endemicity of poliomyelitis.

3 Frequency of repeated tuberculin tests depends on risk exposure of the child and on the prevalence of tuberculosis in the population group. For the pediatrician's office or outpatient clinic, an annual or biennial tuberculin test, unless local circumstances clearly indicate otherwise, is appropriate. The initial test should be done at the time of, or preceding, the measles immunization.

4 May be given at 15 months as measles-rubella or measles-mumps-rubella combined vaccines (see Rubella, section 9, and Mumps, section 9, for further discussion of age of administration).

5 Td—combined tetanus and diphtheria toxoids (adult type) for those more than 6 years of age, in contrast to diphtheria and tetanus (DT) toxoids which contain a larger amount of diphtheria antigen. *Tetanus toxoid at time of injury*: For clean, minor wounds, no booster dose is needed by a fully immunized child unless more than 10 years have elapsed since the last dose. For contaminated wounds, a booster dose should be given if more than 5 years have elapsed since the last dose.

Concentration and Storage of Vaccines

Because the concentration of antigen varies in different products, the manufacturer's package insert should be consulted regarding the volume of individual doses of immunizing agents.

Because biologics are of varying stability, the manufacturer's recommendations for optimal storage conditions (e.g., temperature, light) should be carefully followed. Failure to observe these precautions may significantly reduce the potency and effectiveness of the vaccine.

This material was initially published in the American Academy of Pediatrics' "Report of the Committee on Infectious Diseases," Eighteenth Edition. Copyright American Academy of Pediatrics, 1977. Reprinted by permission.

Table 2
Primary Immunization for Children Not Immunized in Early Infancy¹

<i>Under 6 Years of Age</i>	
First visit	DTP, TOPV, Tuberculin Test
Interval after first visit	
1 mo	Measles, ² Mumps, Rubella
2 mo	DTP, TOPV
4 mo	DTP, TOPV ³
10 to 14 mo or preschool	DTP, TOPV
Age 14-16 yr	Td—repeat every 10 yr
<i>6 Years of Age and Over</i>	
First visit	Td, TOPV, Tuberculin Test
Interval after first visit	
1 mo	Measles, Mumps, Rubella
2 mo	Td, TOPV
8 to 14 mo	Td, TOPV
Age 14-16 yr	Td—repeat every 10 years

¹Physicians may choose to alter the sequence of these schedules if specific infections are prevalent at the time. For example, measles vaccine might be given on the first visit if an epidemic is underway in the community.

²Measles vaccine is not routinely given before 15 months of age (See Table 1).

³Optional.

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Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 12, 1978.

Case Report

Postoperative Acute Cholecystitis

Dr. David Mendelowitz: A 70-year-old man entered the hospital November 14, 1978, with recurrent left renal colic. In 1976, he had a nephrolithotomy for renal stones and a secondary uretero pelvic obstruction. He recovered well, but during the subsequent two years experienced recurrent renal stones. In 1976, he also had his first attack of biliary colic and acute cholecystitis. He was treated conservatively at that time. An oral cholecystogram demonstrated gall stones. He has since had a number of attacks of biliary colic, the most recent about a month prior to admission. Reason given for admission was elective surgery for the renal colic.

Physical examination was essentially unremarkable. He was afebrile; there were no abdominal masses or tenderness. There was a well healed left flank incision. Left pyelolithotomy and extraction of the stones was performed two days after admission. The second postoperative day was marked by a fever of 101.8° F and abdominal distension. The following day, his temperature was 103°F. He was confused, had right upper quadrant abdominal pain and absent bowel sounds. His fever and abdominal distension continued and his abdominal pain was worse on the fifth postoperative day. A diagnosis of acute cholecystitis was made and the patient was taken to surgery. With the use of general anesthesia, a short incision was made and a tense, acutely inflamed gallbladder with a necrotic area at its apex was found. The necrotic area was excised

and a cholecystostomy tube was inserted. Multiple small gallstones were extracted from the gallbladder and a free flow of bile was obtained.

Acute cholecystitis following operations for unrelated disease was first described by Glenn in 1947, who recorded references dating from 1844. A number of other series have since been reported, with approximately 200 cases documented in the literature.

In the majority of cases, acute cholecystitis is an acute inflammatory process involving the gallbladder, which almost always contains calculi. A calculus acute cholecystitis occurs only in about 5-7%. Calculus acute cholecystitis is more common in females and carries a relatively low mortality; even in very large series it approximates only 3-6%. Acute postoperative cholecystitis, however, more often occurs without calculi.

In acute postoperative cholecystitis, symptoms are often masked by the postoperative course. The patient usually has significant abdominal pain from the incision, and may have a mild fever, usually from atelectasis. His postoperative discomfort makes it difficult to determine what is really happening within the abdomen. However, in this setting, acute cholecystitis usually progresses rapidly. In most reports, acute acalculus cholecystitis or postoperative cholecystitis differs statistically from the usual form of acute cholecystitis. Men outnumber women, the patients are older, gallstones are often absent, and the mortality and morbidity are greater.

Review of Literature

Ottinger reported 40 patients with a mortality of 47% in 1976. He found a high incidence of empyema, gangrene perforation of the gallbladder and of ascending cholangitis. An antecedent history of any gallbladder disease was absent in 29 of the 40 patients. Although the onset of the symptoms ranged from about 2 to 50 days after the initial operation, they usually occurred within the first two weeks. The delay between onset of symptoms and final diagnosis was 4-5 days. Most patients began with unexplained fever and the abdominal pain appearing later. A palpable mass was finally present in 50% of the patients. At the time of exploration, 35% in this series did not have calculi, yet half had a gangrenous or perforated gallbladder. In the 26 patients who did have calculi, 15% had common duct stones, and again of those 26 patients, 18 had either empyema, a gangrenous gallbladder, perforation or ascending cholangitis.

Lindberg reviewed over 2,000 soldiers from Viet Nam who had surgery for various injuries and were then transferred to a Philippine hospital. He found 12 cases of acute postoperative cholecystitis. None of these patients reported a history of gallbladder disease prior to having acute postoperative cholecystitis, and one had calculi. The average age was 21 years. The interval from operation to symptoms was about two weeks. Seven of 12 had a gangrenous gallbladder.

These two studies point out the key characteristics of this entity. An antecedent history is not necessary. There is often a delay in the onset of disease and also in establishment of the diagnosis. There is a striking increase in the severity of pathologic change in the gallbladder at the time of surgical treatment. Finally, acute acalculous cholecystitis may occur in the traumatized patient, especially in one who has been given multiple blood transfusions.

The etiology of this problem is uncertain. Calculi, which are present in 50-60%, may play a role in fever. Fasting and dehydration may lead to an increase in the concentration. Viscosity of bile may become inspissated and will not pass through the cystic duct. When the patient eventually takes liquids, the gallbladder becomes obstructed and presumably acutely inflamed. Some feel that biliary stasis alone causes an increase in the bile salt concentration and may cause a chemical cholecystitis. Of course, the opiates and other narcotics that are given postoperatively are known to initiate spasm in the sphincter of Oddi which may, therefore, increase the pressure in

the biliary tree. Finally, older patients may have compromised blood flow through the celiac axis with hypoxia and dehydration. This may be enough to reduce the blood supply to the gallbladder and contribute to gangrenous change.

Once acute postoperative cholecystitis is detected, there are several treatment options: (1) Nonoperative; (2) use of a cholecystostomy tube; (3) cholecystectomy; and (4) cholecystectomy and choledochotomy. Most surgeons prefer removal of the gallbladder if it is technically feasible, and if the patient is stable and not deteriorating. Nonoperative intervention is fraught with danger. Even in those younger patients in the Viet Nam series there was a high incidence of necrotic, gangrenous gallbladders. Finally, a cholecystostomy tube is advocated increasingly by many authors, as stated by Glenn. Older patients cannot tolerate an extensive operation. A short procedure with local anesthesia through a small incision with removal of the stones in the gallbladder can result in survival.

Dr. James Hines: When we saw this patient, his pain was quite severe. While we were preparing for surgery, the pain lessened. Someone on the urology service suggested that he was getting better, but of course what happened was that the gallbladder perforated. At the time of laparotomy, bile was present in the subphrenic space. We removed the gangrenous portion of the gallbladder and implanted a cholecystostomy tube. In spite of intravenous antibiotics he went into septic shock. I don't like cholecystostomies and feel if one can perform a cholecystectomy the patient is really better off. We did the cholecystostomy because he was in such bad shape, and, indeed, he did go into septic shock within six hours. We had a difficult time resuscitating him.

What is the late outcome when you perform a cholecystostomy? At one time we thought that you always had to perform a cholecystectomy at a later date. However, if you use a firm rubber tube, large diameter, and bring it straight out through the abdominal wall, some patients will not need a subsequent cholecystectomy. Without a return of clear bile, you must do an operative cholangiogram, because these patients can have common duct stones. We had clear bile and so felt safe in waiting two weeks to perform a cholangiogram.

After recovering from the cholecystostomy one can electively perform a cholangiogram through the cholecystostomy tube. If stones are seen in the gallbladder or in the ductal system, the patient requires a cholecystectomy. Patients with a normal

cholangiogram should have the tube removed in about 6 weeks. In many cases the gallbladder fibroses and no further surgery is required.

Here are some studies from various institutions: at the University of Oregon, Gingrich found that 17 out of 28 did not require a further operation. In Harvard, England, a small town practitioner reported that only 8 of his 24 remained symptomless and didn't require cholecystectomy; Welch and Harvard found that 21 of 63 required no further operations. In other words, about half of these patients won't need further surgery as the gallbladder fibroses, and they lead a normal life span without further trouble. One of the factors involved is the age of the patient.

Very old patients can just be observed, making no plans to do an elective cholecystectomy. Younger persons with a long life ahead probably should have an elective cholecystectomy because they have a greater chance to reform stones in the gallbladder that remains.

At this time there are four indications for cholecystostomy: acute cholecystitis in a seriously ill patient, in patients with serious technical problems, patients with concomitant pancreatitis and acute cholecystitis in ill patients in the postoperative period.

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Conclusion

Dr. James Hines: In the case described here, the gallbladder should have been removed *before* the renal stones because the patient had a history of repeated gallbladder attacks. I think the point we want to make is that the cystic artery is an end artery; it has no collateral. In the postoperative period the gallbladder disease is a more serious one because it necroses earlier, probably due to poor arterial perfusion.

Dr. John Beal: I think the other point just made is a very important one. When a patient has symptomatic gallstone disease, he will continue to have difficulty. This patient apparently had an episode of acute cholecystitis which was treated without surgery, and if such patients are operated upon for anything at all, they are at high risk of acute cholecystitis. That patient should have had an interval cholecystectomy before reaching the stage of needing surgery for something else. ◀

References

1. Ottinger, L.W.: "Acute Cholecystitis as a Postoperative Complication," *Ann. Surg.* 184, 162, 1976.
2. Glenn, F.: "Acute Cholecystitis," *Surg., Gynec., and Obst.* 143, 56, 1976.
3. Lindberg, E.F., Grinnan, G.L.B., and South, L.: "Acalculous Cholecystitis in Viet Nam Casualties," *Ann. Surg.* 171, 152, 1970.

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Urticaria and Angioedema

BY LOIS MATSUOKA, M.D., AND SIDNEY BARSKY, M.D./CHICAGO

Urticaria and angioedema are common disorders experienced by up to 20% of the population. Although recognition of the disease is seldom difficult, its etiology is often undetermined. This article will review pathogenesis, etiologic characteristics, diagnosis procedures and treatment of urticaria.

Clinical Features

Urticaria is characterized by an eruption of pruritic wheals with raised, erythematous, serpiginous edges and central clearing. The lesions often occur in crops and fade within hours. Histological features are capillary dilatation and transudation of fluid in the upper dermis.

Angioedema involves mucous membranes and often skin. The deep dermis is affected in such reactions. Skin lesions are well demarcated and edematous with little pruritus. Such swellings are commonly found around the mouth and eyes. Edema of the mucous membranes may cause dysphagia, stridor or abdominal discomfort. Death due to asphyxia is rare except in cases of hereditary angioedema.

Urticaria is arbitrarily classified into acute or chronic, depending on whether its duration is longer than six weeks. Acute urticaria often affects young patients as an allergic reaction to foods. Chronic urticaria frequently occurs in middle aged women. Although the cause of acute

urticaria can usually be determined, the origin of chronic urticaria is not found in more than 30% of cases.¹

Mediators

It is generally agreed that histamine is the primary mediator of urticaria. Histamine is stored in granules of tissue mast cells, circulating basophils, and polymorphonuclear cells. It may be released by a variety of nonimmunological and immunological mechanisms to produce vasodilation and increased vascular permeability.

Evidence to support histamine's role is strong. Locally injected histamine produces erythema, flare, wheal and pruritus.² Antihistamines interfere with the urticaria response. Epinephrine, which inhibits the release of histamine, also lessens urticaria attacks.

Kinins, slow-reacting substance of anaphylaxis, and prostaglandin E, may also have a role in urticaria. These mediators, however, have not been thoroughly evaluated.

Non-Immunological Mechanisms

Various drugs and chemical compounds can release histamine directly by mast cell degeneration without an antigen-antibody reaction. Such drugs will often cause wheals when injected subcutaneously and systemic signs of histamine release when administered parenterally. Frequent drug offenders are morphine, codeine, polymyxin, hydralazine, meperidine, and papaverine.³

Physical agents can release histamine. Individuals with linear dermatographism, for ex-

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ample, develop weals after light stroking of the skin. Cholinergic urticaria and certain forms of cold urticaria can be included in this category.

Immunological Mechanisms

Type I reactions: These reactions are the commonest mechanism in allergic urticaria. Anaphylactic reactions occur within seconds or minutes after introduction of the offending agent and may result in urticaria, respiratory distress or hypotension. The mechanism involves IgE (reagin) which is passively attached to mast cells, basophils and neutrophils. Interaction of the antigen (a polysaccharide, protein or hapten) with two specific IgE molecules initiates a series of steps that result in a decrease of cyclic AMP.⁴ This favors release of vasoactive substances such as histamine, kinins, and slow reacting substance of anaphylaxis.⁵

The reagin antibody (IgE) can be passively transferred by injecting the serum of an affected individual into the skin of a normal volunteer. The sensitized skin of the volunteer will react with a wheal and flare when the specific offending agent is introduced. This is known as the classical Prusnitz-Kustner reaction.⁶ It is sometimes used experimentally when a type I reaction is suspected.

Accelerated reactions are hypersensitivity type I states in which urticaria and angioedema occur several hours after introduction of the antigen. For example, individuals with hypersensitivity to the penicilloyl determinant of penicillin (as manifested by positive skin tests and penicilloyl specific IgE antibodies) may develop urticaria several hours after introduction of the penicillin, at a time when IgG antibodies to the penicilloyl determinant are lowered. This suggests that the reaction is mediated by IgE and that IgG may act as a neutralizing antibody to the antigen.⁷

Type II reactions: Cell damage with release of mediator substances occurs when IgG or IgM specific for cell antigens (or foreign antigens adherent on cell membranes) activate the complement pathway. For example, urticaria and other systemic findings may be seen in blood transfusion reactions when complement dependent IgG or IgM react with erythrocyte antigens to release mediator substances.

Evidence in recent years suggests that activation of the entire classical complement pathway is not necessary to produce urticaria. Histamine may be released from cells by the early components of the complement pathway C'3a and C'5a.^{8,9} Further evidence has shown that when

C'3a injected subcutaneously into humans, wheals occur. Histologically, mast cell degeneration is evident.¹⁰ The lesions are inhibited by antihistamines administered prior to injection of C'3a.¹¹

Type III reactions: Antigen-antibody complexes in the presence of complement can release mediators which include histamine.¹² This may be the mechanism involved in the production of urticaria in lupus erythematosus,¹³ some forms of cryoglobulinemia, and serum sickness.¹⁴

Etiologies

Drugs: Ingested and systemically administered drugs are a frequent cause of acute urticaria. Among the common offenders are antibiotics, tranquilizers, analgesics, laxatives and hormones.¹⁵ Penicillin is the commonest cause of drug-induced urticaria. Aspirin exacerbates urticaria in 20-40% of patients with chronic urticaria.¹⁶ The problem of aspirin induced urticaria is compounded by the fact that numerous foods contain salicylates. Furthermore, patients with sensitivity to aspirin often react with asthmatic or urticarial symptoms when exposed to yellow tartrazine, an axo dye found in foods and medicines.¹⁷

Foods: Type I induced urticaria is often caused by nuts, fish or eggs. The offending agent is readily identified by the patient. Histamine may be released nonimmunologically by lobster, egg white, and strawberries causing degradation of the mast cells.¹⁸ Food additives are frequent sensitizers and cross reactivity between tartrazine, salicylates, and benzoic acid derivatives occurs often.¹⁹ Skin testing for food allergy is seldom helpful with the exception of Candida (yeast) tests. A food diary can be a useful diagnostic aid.

Inhalants: Urticaria may be precipitated by pollen, mold spores, animal danders, dust, aerosols and plant products. Such reactions are commonest in atopic patients and are usually accompanied by respiratory complaints. Skin tests with the appropriate agents are often helpful.

Bites and Stings: Hymenoptera stings may cause urticaria by IgE type I mediated mechanisms. The bites of insects such as fleas or mites may cause papular urticaria at the site of trauma.

Contactants: Many substances that penetrate the skin may cause urticaria. Examples are foods and plant products.

Infections: Proteins of infective agents may cause a type I or type II immunological reaction. Although uncommon, Candida, dermatophytes and focal bacterial infections may be im-

plicated as etiologic agents. Urticaria has been reported in up to 30% of non-icteric cases of serum hepatitis.²⁰ Other viral infections which have been implicated are Coxsackie and infectious mononucleosis. Parasitic infections should be suspected when associated with high IgE levels or eosinophilia. Organisms include ascaris, hookworms, and schistosoma. Usually other symptoms such as fever, abdominal pain, or diarrhea are present.

Systemic Disease: Urticaria is an uncommon marker of internal disease.²¹ A careful history and physical exam should be sufficient to eliminate most causes of urticaria due to systemic disease. "Hives" may be associated with collagen vascular disease. Up to 7% of patients with lupus erythematosus or juvenile rheumatoid arthritis may experience urticaria. Neoplasms such as Hodgkin's disease have occasionally been reported in the literature to be associated with urticaria. Wheals are sometimes seen in endocrine abnormalities such as hyperthyroidism or diabetes mellitus.

Systemic involvement (mastocytosis) is present in 30-50% of adults with lesions of urticaria pigmentosa.²³ Skin lesions are reddish brown macules consisting of mast cells which release histamine when stroked to produce localized urticaria and pruritis. In children, urticaria pigmentosa is almost always a cutaneous disease which remits spontaneously.

Genetic predisposition: Hereditary angioedema should be mentioned briefly. This disease results from a nonfunctioning or deficient C₁ esterase inhibitor of the complement pathway. Urticaria rarely occurs with this illness.

A few rare forms of urticaria are inherited as autosomal dominant disorders. Included in this category are vibratory angioedema²⁴ and familial localized heat urticaria.²⁵

Psychological factors: Psychological factors may aggravate urticaria in some cases. Hypnosis has been shown to partially inhibit wheal and flare skin tests²⁶ and passive transfer responses.²⁷ Whether stress alone can produce urticaria is uncertain.

Physical urticaria: These forms of urticaria occur following physical stimuli. Cholinergic urticaria accounts for up to 5% of all cases of urticaria.²⁸ Wheals are 2-3mm in diameter with a surrounding erythematous flare. Exercise, heat or emotional stress can precipitate a reaction.²⁹ It is believed that release of acetylcholine at nerve endings may in some way release histamine. Intradermal injections of nicotine or methacholine

in susceptible individuals will reproduce the lesions and are used as diagnostic tests.

Dermatographism may be produced by stroking the skin in 5% of the general population.³⁰ The involved mechanisms are unknown.

Pressure urticaria occurs four to six hours after pressure is applied.³¹ It is a rare disease manifested by deep, painful swellings. Immunological studies have been negative.

Primary cold urticaria may be familial or acquired. Familial urticaria is usually inherited as an autosomal dominant trait. Burning and erythematous lesions associated with fever, arthralgias, and leukocytosis occur a few hours after exposure to cold.³² Symptoms are noted from an early age. Acquired (essential) urticaria is the commonest form of cold urticaria. It affects predominantly adults. Reactions occur within minutes after exposure. Symptoms may be localized (wheals occurring after application of a cold object to the skin) or generalized (syncope after swimming in cold water). Passive transfer tests with IgE are often positive for this form of cold urticaria.³³ Secondary cold urticaria is cold sensitivity which may occur with cryoglobulinemia, cryofibrinogenemia, cold hemolysis, syphilis, and hematopoietic malignancies.

Diagnostic Procedures

A complete history and physical exam with emphasis on the causes previously mentioned is the most important step in determining the cause of urticaria. In a few forms of urticaria, physical examination of the skin is helpful. Lesions of dermatographism are often linear. "Yellow hives" may be seen in serum hepatitis. The brownish papules of urticaria pigmentosa will wheal on stroking. Urticaria on exposed areas of the body may indicate light or cold sensitivity.

Laboratory tests may be helpful when indicated by the history and physical exam. A complete blood count is a good screening device. Eosinophilia is common in allergic reactions. Glucose, liver profile, urinalysis and thyroid studies may be ordered when systemic disease is suspected. Serum complement levels, rheumatoid factor and ANA can be important in diagnosing collagen vascular diseases. The VDRL and tests for cryoglobulins, cryofibrinogens and cold hemolysins are useful in suspected cases of cold urticaria. In cases of infection, stool for ova and parasites, IgE, heterophile antibody, or vaginal smears for Candida and trichomonas may be helpful.

"Skin tests" such as application of an ice-cube with wheal production is a good diagnostic aid

for cold urticaria. Similarly, stroking of the skin in dermatographism, ultraviolet light exposure in solar urticaria, and subcutaneous injections of methacholine in cholinergic urticaria are helpful. Scratch and intradermal test are useful in cases of inhalant allergies.

Treatment

In acute cases of urticaria 0.3ml of 1:1000 epinephrine subcutaneously is useful until antihistamines are effective. The antihistamines are the mainstay of management of most types of urticaria. The choice of antihistamine depends on the efficacy and side effects in each individual. There are few comparative trials of antihistamines to show the advantages of any one drug. In certain extremely refractory cases of chronic urticaria, corticosteroids may (inexplicably) be of benefit.

This article has briefly discussed immunological reactions as regards to urticaria. Future articles of Immunology Seminars will cover IgE hypersensitivity reactions and cytotoxic effects in depth.

References

A complete list of references for "Urticaria and Angioedema," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Obituaries

**** Ahlvin, Reno Arthur**, Mesa, Arizona, formerly from Kankakee, died at the age of 82. Dr. Ahlvin was a 1926 graduate of Washington Medical School in St. Louis.

*** Brixey, Albin Monroe, Jr.**, Joliet, died March 8, 1979, at the age of 62. Dr. Brixey was a 1943 graduate of the University of Oklahoma School of Medicine.

**** Brodny, M. Leopold**, Chicago, died March 11, 1979, at the age of 74. Dr. Brodny was a 1928 graduate of Tufts Medical School. He was formerly on the staff of Weiss Memorial Hospital.

**** Chesrow, Eugene J.**, Oak Forest, died March 3, 1979, at the age of 85. Dr. Chesrow was a 1914 graduate of the Chicago College of Medicine and Surgery. He had served as Medical Administrator of Oak Forest Hospital for 30 years.

*** Gregowicz, John J.**, Belleville, died March 3, 1979, at the age of 61. Dr. Gregowicz was a 1944 graduate of the St. Louis University School of Medicine.

*** Kirby, William J.**, West Palm Beach, Florida, formerly from Chicago, died February 24, 1979 at the age of 82. Dr. Kirby was a 1931 graduate of Rush Medical College.

*** Kurtz, Charles Glenn**, Forest Grove, Texas, formerly of Kewanee, died February 5, 1979, at the age of 73. Dr. Kurtz was a 1934 graduate of Chicago Medical School.

*** Milewski, Edward Walter**, Chicago, died March 11, 1979, at the age of 70. Dr. Milewski was a 1936 graduate of the Chicago Medical School.

**** Moore, Jean Woll**, Danville, died March 6, 1979, at the age of 82. Dr. Moore was a 1925 graduate of the University of Indiana.

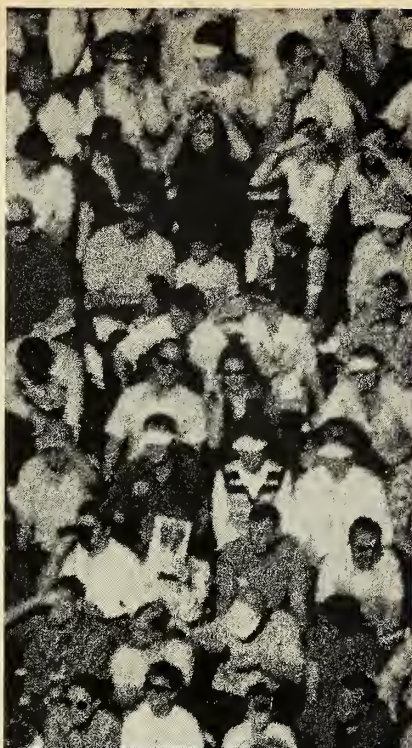
*** Sable, Arthur D.**, Oak Park, died March 4, 1979, at the age of 55. Dr. Sable was a 1951 graduate of St. Louis University Medical School.

**** Seed, Linden**, Oak Park, died March 3, 1979, at the age of 82. Dr. Seed was a 1921 graduate of Rush Medical College. Dr. Seed had served on the staff of Grant Hospital for more than 50 years.

**** Soroosh, Rustem**, Chicago, died October 15, 1978, at the age of 87. Dr. Soroosh was a 1921 graduate of Loyola University Stritch School of Medicine.

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Fetal Alcohol Syndrome Conference Announced

ISMS has joined the Chicago and Rosemont Chapters of the Illinois Nurses' Association as well as Lutheran General Hospital, in co-sponsoring a workshop coordinated by the Governor's Citizens Advisory Council on Alcoholism and the Governor's Planning Council on Developmental Disabilities.

In Illinois, approximately 2,200,000 women are of child-bearing age. Recent statistics estimate that 150,000 of these women are heavy drinkers. Importantly, women in the age range 20-24 have the greatest number of children and also the highest rate of heavy drinking.

In 1977 there were more than 170,000 live births recorded for Illinois residents. Approximately 11,500 of the children were born to women who drank heavily. Statistically, up to 8,000 of these children can be expected to manifest one or more of the symptoms of Fetal Alcohol Syndrome, defined as that combination of physical and emotional anomalies found to consistently occur among children of heavily drinking mothers and of some mothers who drink moderately.

The conference will seek to achieve five specific goals: (1) to educate the professional and lay public about the effects of alcohol on the unborn; (2) to foster awareness and identification of women at child-bearing age who are at risk, and provide information relative to their special treatment needs; (3) to provide input to physicians, nurses and other clinicians on suggested intervention strategies for counseling pregnant

women; (4) to disseminate informational aids for identification and treatment of the child with FAS; and (5) to provide exposure to the ongoing research now in progress.

Among the national experts serving as faculty for this conference will be leading FAS researchers, diagnosticians, and clinicians, including David W. Smith, M.D., Professor of Pediatrics, University of Washington, Seattle, and Kenneth L. Jones, Jr., M.D., Assistant Professor, University of California, San Diego, and Henry L. Rossett, M.D., Associate Professor of Psychiatry, Boston University School of Medicine. These three physicians are considered to be responsible for focusing national attention on the fetal alcohol syndrome through their research and work in this area.

The workshop will address historical perspectives of the Fetal Alcohol Syndrome, and faculty will discuss their respective theories, foci and general approaches. Topics will include the unresolved question of how much drinking is harmful to the fetus and in which trimester of pregnancy damage is most likely to occur.

Participant physicians will be eligible to receive Category 1 CME credits. Continuing Education Units have been authorized for nurses and Division of Alcoholism personnel. The conference fee is \$25.00. For more information, call Emma C. Redmond, Division of Alcoholism, IDMHDD, (312) 793-2907.

Abstracts of Board Actions

(Continued from page 284)

his rights have been restricted; and (2) Eliminate a provision that prevents clinicians from testifying in involuntary commitment proceedings if they have not given the patient a "Miranda-type" warning.

- Exempt from liability physicians who respond to any "medical emergency occurring within a hospital."

ISMS will *oppose* the following pending legislation which would:

- Legalize use of chymopapain in Illinois. ISMS opposition is tied to lack of FDA approval of the drug. In addition, ISMS will: (1) Urge AMA to call on FDA to support continued research into use of chymopapain; and (2) Support a joint House/Senate resolution calling on Baxter Laboratories—developers of the drug—and FDA to place chymopapain in phase IV status (investigational drug) . . . and urge a complete review of FDA procedures.
- Set responsibility for claim payment in cases where "medical necessity" judgments—under the Blue Cross/Blue Shield Medical Necessity Program—are submitted for peer review. Under the bill: (1) If the procedure is judged "medically necessary," the insurance company would pay the claim—within policy limits— and attorney fees incurred during the appeal; and (2) If the procedure is judged "medically unnecessary," the physician would be forced to hold the patient "harmless" from any expenses incurred because of the procedure or attorney fees resulting from the appeal.

BLUE CROSS/BLUE SHIELD MEDICAL NECESSITY PROGRAM

ISMS will urge Blue Cross/Blue Shield to rely upon hospital UR committees for initial review of cases under the carrier's controversial Medical Necessity Program. The procedure will be recommended for all cases not covered by review contracts between BC/BS and other organizations. If the "medical necessity" ruling is appealed, the Board will urge BC/BS to seek the assistance of a county medical society which could refer the matter to its local foundation for medical care or other appropriate review organization. BC/BS also will be urged to request county societies to perform peer review of all questionable ambulatory cases—exclusive of fee adjudication.

MEETINGS IN WASHINGTON, D.C.

Noting the need for improved communication with the Illinois Congressional Delegation and federal agencies on major health legislation, the Board voted to hold its 1980 winter meeting, February 3-6, in the nation's capital in conjunction with a Washington Roundup program. In addition, the Board authorized appropriate members and staff to make one or more trips to Washington during the year to discuss legislative issues with Congressmen.

IDPA DATA DEMANDS UNDER MMIS

ISMS will support PSROs and hospitals in limiting IDPA's data access to aggregate reports and avoiding duplicate collection reports. Gearing up to bring hospitals under its Medicaid Management Information System (MMIS), IDPA is demanding "identified" discharge data and information on PSRO reviews of hospital stays. If PSROs refuse to provide the data, hospitals will be required to directly provide the information. This would force hospitals to duplicate services of data agencies—which currently collect discharge information—and shoulder new administrative costs. Failure to meet the data requirements could cause IDPA to recoup Medicaid payments to hospitals. Several PSROs are balking at IDPA's request, maintaining that: (1) Release of "identified" data violates confidentiality; and (2) IDPA does not need certain requested PSRO review data for claims payments.

Once the hospital conversion to MMIS is completed, IDPA plans to bring physicians under the system. The transfer of physicians billings tentatively is scheduled for July. ISMS will express concern to IDPA over the lack of ISMS-IDPA discussions on implementation of MMIS and request regular meetings to discuss potential problems. Of primary concern is the new Medicaid enrollment billing forms that will be required under the system. ISMS will voice strong objection to both forms.

In related actions, the Board voted to:

- Assist and encourage the Chicago Foundation for Medical Care and Medical Utilization Review for Southern Illinois to seek IDPA support for PSROs in these areas to serve as appeal bodies for physicians wishing to dispute IDPA determinations—based upon bill payment or audit—of medical necessity and appropriateness of care.
- Voice concern to IDMHDD over the provider agreement form used in the IDMHDD-IDPA program to provide psychiatric care for the indigent. The concerns focus upon: (1) Patient confidentiality; (2) Set fee for services in a given period; and (3) A requirement that the physician agree to a "one-way" reconciliation during audits.

FINANCIAL MATTERS

Acting upon recommendations of the Finance Committee, the Board:

- Approved exercising the option to purchase the computer which ISMS had been leasing for nearly three years. Also, ISMS will purchase an additional "memory" unit to meet increasing demands of the Society and Inter-Insurance Exchange for computer services.
- Authorized changing the ISMS Employee Retirement Plan to a multi-employer retirement program so it can be used by county medical society staff.
- Increased the annual honoraria for the president and Board chairman to \$20,000, and president-elect to \$10,000, effective in May, 1979.

HOUSE OF DELEGATES RESOLUTIONS

The Board will introduce resolutions at the upcoming House of Delegates meeting that, if adopted, would:

- Streamline the Interim Sessions of the House.
- Revise Chapter XII of Bylaws dealing with peer review.
- Direct ISMS to discourage smoking by: (1) Recommending that physicians and their employees refrain from smoking during patient contacts; (2) Recommending that physicians give advice and provide literature and signs concerning the health hazards of smoking; and (3) Cooperating with the Illinois Inter-agency Council on Smoking and Disease and its component agencies regarding availability of such literature and signs.
- Establish a policy on second opinions identical to that of AMA. The Policy would state: "Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, ISMS: (1) Reaffirms the right of a patient or a physician to seek a second opinion freely from any physician of his/her choice; (2) Opposes the concept of mandatory second opinions or the imposition of financial penalties by a third party for not obtaining a second opinion; and (3) Supports the concept that, when a second opinion is required by a third party payor, that second opinion should be at no cost to the patient."

SPECIAL PROGRAMS

Acting on requests concerning special programs planned by outside organizations, the Board voted to:

- Endorse an Illinois Department of Public Health-McDonald's Corp. campaign to promote immunization by having physicians distribute free food coupons to children meeting immunization requirements. IDPH will be informed that the ISMS endorsement should be publicized only in a letter to physicians encouraging their participation.
- Co-sponsor with the SIU School of Medicine's Health System Research Department a Doctor's Job Fair for central and southern Illinois in Springfield. The Fair—which will be held this summer or fall—is intended to complement the ISMS Doctor's Job Fair held each year in Chicago. The Sangamon Medical Society will be asked to participate in Fair planning. ISMS co-sponsorship involves staff assistance but no financial commitment.

COUNTY SOCIETY CHARTER

ISMS will withdraw the charter of the Edwards County Medical Society which was dissolved last December. The three Edwards County members have joined the Wayne and Richland County Medical Societies.

COST CONTAINMENT

The ISMS-sponsored Task Force on Cost Effectiveness will urge all hospital medical staffs to review their standing orders and eliminate those which they believe are not cost effective.

CONSTITUTIONAL AMENDMENT

The Society will join AMA in supporting an amendment to the U.S. Constitution— *via the Congressional process*—prohibiting deficit spending. Last year, the AMA House voted to support the amendment which already has been the subject of some 40 resolutions in Congress. In addition, approximately 28 state legislatures have passed resolutions requesting Congress to convene a Constitutional Convention on this issue. However, AMA does not support the Convention approach because other changes could be made under that procedure. ISMS will notify the Illinois Congressional delegation of its position.

IMPARTIAL MEDICAL EVALUATION

The Board rejected a request by the Illinois Industrial Commission that the Society provide impartial medical evaluation for the Commission in Workman's Compensation cases. ISMS will suggest that the Commission establish its own impartial panel and also offer to assist the Commission in structuring the evaluation system.

FEE ADJUDICATION

The Board cautioned those county medical societies involved in fee review activities that they may face the threat of Federal Trade Commission (FTC) action. The warning followed a detailed review by legal counsel and ISMS officers of FTC actions nationwide against medical organizations engaged in fee adjudication. A discussion slated for the next Board meeting may result in specific recommendations on the issue.

GOVERNMENT INFLUENCE ON COST OF MEDICAL CARE

Arthur Young & Co. will be asked to prepare a proposal outlining a study designed to document the cost to physicians of government regulations. The firm, which already has analyzed government regulations' impact on hospital costs, will develop a proposal—without cost or obligation—outlining the study's proposed scope, benefits and cost. Last November, the ISMS House of Delegates referred to the Board a resolution calling for the study.

COMPREHENSIVE, PREPAID ISMS PROGRAM

ISMS will explore with the Illinois State Medical Inter-Insurance Exchange the feasibility of developing a comprehensive prepaid medical care program which could be made available to county medical societies or groups of societies that wish to form Individual Practice Associations (IPAs). The action was in response to requests from two county societies interested in establishing IPAs which could deliver comprehensive health insurance benefits which maintain broad access and fee-for-service among practitioners. In addition to its discussions with the Exchange, ISMS will develop sources and costs of consultation services for creation of such a plan.

IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Adatuss DC Expectorant, Ethaverine (Circubid, Cebral, Eta-Lent, Ethaquin, Ethatab, Isovox-100, Papavatrul L.A.), Maxigesic CIII, Maalox Therapeutic Concentrate, Nitrol, Gly-Oxide, Tavist (clemastine fumarate), Vicodin, and Manol (Cefamandole nafate).

APPOINTMENTS/NOMINATIONS

The Board approved the following appointments:

- *Dr. Larry Gratkins*, Evanston—Resident Physicians Section representative to Council on Medical Service
- *Dr. Benjamin LeCompte*, Chicago—Resident Physicians Section representative to Medical-Legal Council
- *Dr. Kofi Amankwa*, Springfield—ISMS representative to Illinois Bureau of the Budget's Task Force for the Prevention of Developmental Disabilities
- *Drs. Mather Pfeifferberger*, Alton; *Harvey Scott*, Jacksonville, and *Randolph Seed*, Chicago—Illinois Department of Public Health Committee to analyze a surgical assistant experimental program conducted at St. John Hospital and Memorial Medical Center, Springfield. Three members of the Illinois Hospital Licensing Board also will serve on the committee.
- *Dr. Bernard Baalman*, Hardin—ISMS representative to the 1979 AMA National Conference on Rural Health—April 18-21, in St. Paul, Minn.—replacing Dr. Larry Plummer, Jerseyville.
- *Drs. Charles Frazer*, E. St. Louis; *David Roxe* and *Robert Stepto*, both of Chicago—Urban Subcommittee of the Physicians Recruitment Committee.
- *Drs. James Ekeberg*, Palatine; *Eli Borkin*, Carbondale; *Raymond Dieter*, Glen Ellyn; and *Constantine Soter*, Northbrook—Illinois Medical Journal Editorial Board. Re-appointed for two year terms.

Named to serve as the ISMS Committee on New Health Practitioners—functioning under the Council on Education and Manpower—were: *Drs. Pedro Poma*, Chicago, chairman; *Harold Zenisek*, Rockford; and *John Froiland*, Chicago. Trustee consultants will be *Dr. Joseph Perez*, Rockford, and *Morris Friedell*, Chicago.

Appointed to the Committee to Coordinate Local Student Business Session (SBS) and Resident Physicians Section (RPS) activities were: *Drs. Craig Booher*, Rockford, and *James W. Bauer*, Peoria. Named ex-officio members were: *Dr. Ira Isaacson*, Chicago, RPS Governing Council chairman; and *Daniel Shirey*, Oak Park, SBS Governing Council chairman. The Committee was placed under the Council on Education and Manpower and given a \$1,000 budget for 1979, with funds allocated from the special assessment for RPS and SBS activities.

ISMS nominees for the All-American Medical Hall of Fame are: *Drs. Ludwig Hektoen*, *James Herrick* and *Nicolas Senn*, all of Chicago. The Hall of Fame—created by the St. Louis Medical

Society—is designed to honor physicians for outstanding work in office practice, teaching, research and hospital, government or medical service.

Dr. Morris Friedell, Chicago, was named the ISMS representative to the Medical Advisory Board to the Neutron Therapy Center of Chicago.

Drs. Lawrence L. Hirsch, Chicago, and *Donald Pochyly*, River Forest, will be nominated for appointment to the AMA Council on Medical Education when a vacancy occurs.

The following physicians were nominated for appointment to advisory committees of the AMA's Council on Education and Manpower:

- *Drs. Fred Z. White*, Peoria, and *Lee Rogers* and *K. J. Thampy*, Chicago—Advisory Committee on Graduate Medical Education
- *Drs. Eugene Rogers* and *Donald Wharton*, Chicago—Committee on Allied Health Education and Accreditation
- *Drs. Craig Booher*, Rockford, and *Edwin Liebner*, Chicago—Liaison Committee on Medical Education
- *Drs. Lee Rogers*, *Antonio Scommegna* and *K. J. Thampy*, all of Chicago—Liaison Committee on Graduate Medical Education
- *Dr. Frank E. Sedlak*, Riverside—Liaison Committee on CME

Nominated for appointment to the AMA Council on Education and Manpower's residency review committees for various specialties were: *Drs. Thomas Andrews*, Hinsdale—Dermatology; *Sam Sugar*, Evanston—Internal Med.; *Pedro Poma*, Brookfield, and *Antonio Scommegna*, Chicago—Ob-Gyn; *Richard Perritt*, Chicago, and *David Robbin*, Glen Ellyn—Ophthalmology; *Alfred Kiessel*, Decatur—Pathology; *R. N. Pesch*, Wheaton and *Eugene Rogers*, Chicago—Phy. Med. & Rehab.; *Richard Buegner*, *Leon Love* and *Lee Rogers*, all of Chicago—Radiology; and *Dean Bordeaux*, Peoria;—Family Practice.

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As the first professional organization for medical assistants (founded 1956), AAMA pioneered in developing the only certification program in this field. A medical assistant who successfully completes the basic examination is identified as a Certified Medical Assistant (CMA). Specialty categories include administrative (CMA-A), clinical (CMA-C), and pediatric (CMA-Ped). More than 7,500 certificates have been earned since the first examination was given in 1963.

The AAMA pioneered in the development of curriculum standards for medical assisting programs. The American Medical Association, in collaboration with AAMA, is recognized as an official accrediting agency for such programs by the U.S. Office of Education.

On five different occasions the AMA House of Delegates has passed resolutions commending the objectives of AAMA, endorsing its functions, and urging every physician to encourage medical assistants to join the association in order to benefit from its educational programs.



To help your medical assistants do a better job of helping you, urge them to join AAMA—the professional association dedicated to their continuing education. Fill in the attached coupon and mail it today. Your practice deserves the best.

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Names of assistants

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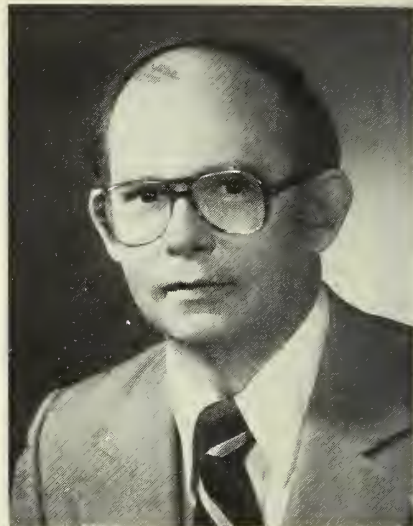
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Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

The Level of the Herd

"It is the American vice, the democratic disease which expresses its tyranny by reducing everything unique to the level of the herd."

Henry Miller, "RAIMU"



Each patient is unique. The practice of medicine—the art and talent of treating patients—shares that uniqueness. In fact, it stands as a classic definition of the term.

The variations in diagnosis, unpredictability of disease and volatility of behavioral interaction defy "cookbook" classification. Yet, it is because of the unique flexibility required in medical practice that our profession is under assault.

Social planners and government bureaucrats are prone to demand that whatever is not well understood must—at least on the surface—be transformed into something simplistic. Those demands now are being applied to the practice of medicine:

- HSA boards—employing finite selectiveness—have the potential to impose plans for mediocrity.
- Government regulations are penned to achieve statistical averages, and make no allowances for deviations at both ends of the curve.
- The demand for cheap "me too" pharmaceuticals stifles research for new pharmacological agents.
- Quests for grants in exploratory basic science research are falling prey to pragmatics.
- Extensive encroachment by para-professionals into the practice of medicine threatens to create a substandard overall level of care that hardly can be termed unique.

The potential results of these activities must be viewed as a vivid illustration of Henry Miller's apt, frighteningly true, thesis: It is tyranny to reduce something grand and unique "to the level of the herd."

The alarming movement to destroy the uniqueness of medical practice can be halted only by physicians who employ their professional uniqueness as a counterbalance. We must become activists, demonstrating that unique approaches—not simplistic formulas—must be the basis of solutions to medical problems. ◀

A handwritten signature in dark ink, appearing to read "P. John Seward". The signature is fluid and cursive, with a small flourish at the end.

P. John Seward, M.D., President

Doctor's News

HISTORY OF MEDICINE AVAILABLE—ISMS published *History of Medical Practice in Illinois*, Volume II, in 1955. The volume, which has been lauded by medical historians, was edited by David J. Davis, M.D., Ph.D., who was ISMS' official historian at that time. (ISMS had published Volume I of that series, which covers the years 1800-1850, in 1927. The first volume is out of print.) Volume II records medical practice in Illinois between 1850 and 1900. Available through the Society offices at a cost of \$10.00, it could become a valuable part of any physician's library. Persons interested in obtaining a copy of Volume II, *History of Medical Practice in Illinois*, are urged to contact the *Illinois Medical Journal*.

PEDIATRIC JOURNALISM AWARD—The American Academy of Pediatrics has announced that entries are being accepted for its annual Pediatric Journalism Award. Pertinent articles must have been published between July 1, 1978 and June 30, 1979. Awards are designated in four categories: general interest, large newspapers, small newspapers and magazines published in the US. Medical or other professional journal publications are not admissible. The final deadline for receipt of articles is July 31, 1979. For further information, contact the American Academy of Pediatrics, Department of Communications, 1801 Hinman Avenue, Evanston, IL 60204.

ALCOHOL AND DRUG UPDATE—The fifth annual Illinois Teenage Institute on Substance Abuse is scheduled for July 17-21 at East Bay Camp in Bloomington. Co-sponsored by the Illinois Alcoholism and Drug Dependence Association, Dangerous Drugs Commission, IDMHDD, Division of Alcoholism and Illinois Office of Education, the Institute is intended to bring together about 150 Illinois high school students to learn and exchange information about alcohol and drug abuse. Cost to each student, who must be either a junior or senior in high school with passing grades willing to serve as a resource to community groups after completion of the program, is \$100. The Institute is *not* intended to serve as a therapeutic setting for persons presently experiencing emotional or physical problems deriving from substance abuse. "All efforts," their publication states, "will be made to insure that the institute does not take on the responsibility of providing individual or group treatment." The program is staffed by professionals from universities, social service groups and government agencies involved with youth and other substance abuse problems. Physicians who might know of students interested in the program who meet the above-noted qualifications may instruct them to contact: Teenage Institute on Substance Abuse, 1035 Outer Park Drive, Suite 310, Springfield, IL 62704, before June first.

EMERGENCY MEDICINE SEMINAR—A one-day seminar on emergency services deployment will be sponsored in August at Wayne State University in Detroit, Michigan. Designed for emergency medical personnel as well as police, fire and city management professionals, the program is designed to explore common problems in resource allocation, as well as available techniques now in use. For further information, contact Ms. Joanne Juhl, College of Engineering, Wayne State University, Detroit, MI 48202; (303) 577-4707.

PHYSICIANS IN THE NEWS—**David S. Forkosh, M.D.**, Chicago, medical director of Forkosh Memorial Hospital, has been appointed to the Board of Directors of the American Academy of Medical Directors. . . . **Anthony Barbato, M.D.**, Oak Park, has been named associate dean for academic programs at the Loyola University Stritch School of Medicine. Dr. Barbato, it was announced, will continue to serve as director of continuing medical education at Loyola. . . **Joseph B. Kirsner, M.D.**, Chicago, is one of ten 1979 recipients of the coveted Horatio Alger Award. Kirsner, chief of the University of Chicago Hospitals and Clinics, 1971-1976, and honorary chairman of the Gastro-Intestinal Research Foundation, was among those named in honor of "pulling themselves up by their bootstraps in the American tradition."

Joseph M. White, M.D., has been elected president of the University of Health Sciences/Chicago Medical School. Dr. White, former provost for Health Affairs at the University of Missouri-Columbia, is chairman-elect of the Coordinating Council on Medical Education, the national coordinating body for CME.

A two-day scientific symposium sponsored by the Rush Cancer Center of Rush-Presbyterian-St. Luke's Medical Center and Mt. Sinai Hospital Medical Center has been named for **Israel Davidsohn, M.D.**, professor of pathology at Rush and director of the Department of Experimental Pathology at Mt. Sinai. Dr. Davidsohn is best known for development of the red cell adherence test for diagnosis and early detection of certain types of cancer, and also for development of the first reliable test for mononucleosis.

David W. Cromer, M.D., recently accepted the 1978 Northwestern Alumni Service Award from Northwestern University Medical School. Dr. Cromer received the award in recognition of "exceptional voluntary service to the University," as a member of their Alumni Council since 1972 and its president 1975-1977. . . . **Joseph A. Tarkington, M.D.**, has been named to the Arlene and Marshall Bennett Chair of Neurosurgery at Evanston Hospital and Northwestern University. Dr. Tarkington is an associate professor of neurosurgery and head of the neurosurgery division at Evanston Hospital. . . . **Henry L. Nadler, M.D.**, was granted the Northwestern University Alumni Merit Award for 1978, granted each year to an alumnus who has "distinguished achievement in their particular profession or field of endeavor in such a way as to reflect credit upon their alma mater." Dr. Nadler is chairman of Northwestern's department of pediatrics and chief of staff as well as head of the division of genetics at Children's Memorial Hospital.

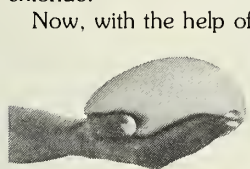
Rowine H. Brown, M.D., medical director of Cook County Hospital, recently received one of the 1979 Illini Achievement Awards. The award, given to three persons each year, is the highest honor bestowed on graduates by the UI Alumni Association. . . . Newly elected officers at St. James Hospital in Chicago Heights include **Stefan A. Dekowski, M.D.**, Olympia Fields, president, **Lowell Goldberg, M.D.**, Olympia Fields, vice president, and **Richard Moutvic, M.D.**, Crete, secretary-treasurer.

The Chicago Society of Plastic Surgery has elected new officers. Those so honored are **Stuart J.F. Landa, M.D.**, Chicago, president, **Martin C. Robson, M.D.**, Chicago, vice president, **Richard L. Sperling, M.D.**, Skokie, secretary, and **Norman E. Hugo, M.D.**, Barrington, treasurer. In a related note, **Richard C. Schultz, M.D.**, Park Ridge, chief of the division of Plastic Surgery at the UI Medical Center in Chicago, has been named president of the Midwestern Association of Plastic Surgery. Dr. Schultz also serves on the staffs of Lutheran General and Northwestern Community Hospitals.



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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

June

Family Therapy WORKING WITH THE DIVORCE PROCESS

For: Psychiatrists, therapists. 1-day workshop, June 8, Chicago. Speaker: Jean Goldsmith, Ph.D. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsor: Northwestern University Medical School. Fee: \$40. Credit: AMA Category 1, 6 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-649-7285.

Family Therapy A DAY WITH VIRGINIA SATIR

For: Psychiatrists, therapists. 1-day workshop, June 30, Hyatt Regency Hotel, Chicago. Speaker: Virginia Satir. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$40. Credit: AMA Category 1, 6 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-649-7385.

Immunohematology MANAGEMENT OF ACUTE BLOOD LOSS

For: MD's, nurses, technologists. Lecture, June 21, 7:00-9:00 p.m., Moline. Speaker: John Collins, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., P. O. Box 70, Davenport, Iowa 52803. Fee: \$10. MD's; \$2, others. Reg. limit: 200. Credit: AMA Category 1, 2 hours; AOA, 2 hours; AAFP Prescribed, 2 hours. Contact: Pat Harrod. Phone: 319-359-5401.

Medicine SELECTED RECENT ADVANCES IN CLINICAL MEDICINE

For: GP's. Lecture, June 14, 9:00 a.m., Chicago. Sponsor: The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Chicago 60637. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312-947-5777.

Medicine NEW TRENDS IN THERAPEUTICS

For: MD's. Symposium, June 2, 1:00 p.m., Newton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone 217-782-7711.

Ophthalmology OPHTHALMIC MICROSURGERY

For: Ophthalmologists. 3-day course, June 6-8, Chicago. Speaker: Jared Emery, MD. Sponsor: Dept. of Ophthalmology, Abraham Lincoln School of Medicine, University of Illinois College of Medicine, Office of Continuing Education, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: 20. Fee: \$550. Credit: AMA Category 1, 20 hours. Contact: Sue Korienek. Phone: 312-996-8025.

Pain NEUROMUSCULOSKELETAL PAIN: CURRENT CONCEPTS (INCLUDING ACUTHERAPY AND AURICULOTHERAPY)

For: MD's, students. 3-day course/symposium, June 22-24, Chicago. Sponsor: Dept. of Rehabilitation, The Chicago Medical School, 2020 W. Ogden, Chicago 60612. Cosponsor: North American Academy of Auricular Medicine & Acupuncture Research. Reg. deadline: 5/31. Fee: \$200. Reg. limit: 150. Credit: AMA Category 1, 20 hours. Contact: Eugene Rogers, MD, FACP. Phone: 312-942-2755.

Pathology CURRENT TOPICS IN BLOOD BANKING

For: Pathologists, medical technicians. Lecture, June 7-8, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. Fee: \$120. Reg. limit: 500. Credit: AMA Category 1, 14 hours; AAFP Elective, 14 hours. Contact: Floyd Pennington. Phone: 313-764-2287.

Primary Care CARDIAC SYMPTOMS, ARRHYTHMIAS, AND HOLTER MONITORING

For: GP's, Internists. Lectures/workshops, June 15-17, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Dr. E., Englewood, Colorado 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Pulmonary Disease DIAGNOSTIC & THERAPEUTIC DECISIONS IN PATIENTS WITH PULMONARY DISEASE

For: MD's. Course, June 6-8, Chicago. Sponsor: American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104. Cosponsors: Cook County Hospital; University of Illinois. Fee: varies. Reg. limit: 300. Credit: AMA Category 1, 18 hours. Contact: Linda Salsinger. Phone: 215-243-1200.

Rehabilitation TOTAL MANAGEMENT OF THE STROKE PATIENT

For: MD's, residents, nurses. Course, June 4-8, Chicago. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 5/15. Fee: \$200, MD; \$100, other. Reg. limit: 100. Credit: AMA Category 1, 30 hours. Contact: Don Olson. Phone: 312-649-6179.

Surgery/Oncology LAKE COUNTY MEDICAL/SURGICAL SEMINAR

For: MD's, DDS's, RN's, DO's, RPH's. Seminar, June 19, Waukegan. Speakers: Thomas Gynn, MD; M. Scott Peckler, MD; Richard Vasquez, MD. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan 60085. Reg. deadline: 6/18. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AOA, 5 hours; AAFP Elective, 5 hours. Contact: R. Adelman, MD. Phone: 312-688-5800.

July

Family Therapy FAMILY SYSTEMS ASSESSMENT (INTRODUCTORY COURSE)

For: beginning family therapists. 5-day course, July 9-13, Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Reg. limit: 24. Fee: \$155. Credit: AMA Category 1, 30 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-640-7385.

Primary Care CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION

For: GP's, Internists. Lectures/workshops, July 27-29, Lake Geneva, Wis. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, Colorado 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

August

Pediatric Dermatology THE SECOND INTERNATIONAL CONGRESS OF PEDIATRIC DERMATOLOGY

For: Dermatologists, Pediatricians. Lectures/workshops, August 23-26, Chicago Marriott Hotel. Sponsor: University of Illinois at the Medical Center, Office of Cont. Educ. Services, 1855 W. Polk St., Room 144, Chicago 60612. Cosponsors: Abraham School of Medicine, Dept. of Dermatology; Int'l. Society of Pediatric Dermatology; American Society of Pediatric Dermatology; Chicago Dermatological Society. Reg. deadline: 8/1. Fee: \$205; \$175, members Int'l./Amer. Soc. of Ped. Derm. Credit: AMA Category 1, 27 hours. Contact: JoAnn Kohn. Phone: 312-996-8025.

Rehabilitation ELECTROMYOGRAPHY AND CLINICAL NEUROPHYSIOLOGY

For: MD's with background in EMG. Course, August 15-18, Chicago. Sponsor: Rehabilitation Institute of Chicago/Medical Rehabilitation Research & Training Center #20: Northwestern University Medical School, Rehabilitation Institute of Chicago—Education & Training Dept., 345 E. Superior St., Chicago 60611. Cosponsor: American Academy of Physical Medicine and Rehabilitation. Speaker: Ian C. MacLean, MD. Reg. deadline: 7/30. Fee: \$195, physicians; \$90, residents. Reg. limit: 100. Credit: AMA Category 1, 26 hours. Contact: Don Olson, PhD. Phone: 312-649-6179.

Weekend Workshop

Introduction To CME Technique

**An intensive weekend workshop FOR Hospital DME's and
Program Chairman, Medical Faculty, other CME Planners—**

June 15-16, 1979

Friday 1:30 PM to Saturday 5:15 PM

Oak Brook Hyatt House, Oak Brook, IL

Dorset Room

This workshop takes account of the findings of both research and experience that physician continuing education is most satisfying if it occurs both individually and in groups at organized CME programs planned by the learners in a hospital setting. The workshop aims to help you analyze your hospital setting and understand how you can use proven education principles to start a new, or improve an existing, CME program.

This is a *repeat* of the successful workshop offered last December—which proved so attractive that it was oversubscribed. We urge your prompt registration.

For further details on program, schedule, and cost; write or call:

**Illinois Council on Continuing Medical Education
55 East Monroe, Suite 3510, Chicago, IL 60603
Telephone: (312) 236-6110**

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BUNKER HILL: Rural community, trade area 3000. Doctor retiring. Living quarters and office space available. Excellent schools and churches. Fifty miles, north-east of St. Louis, Mo. Financial assistance available if necessary. Contact: Sally Bruckert, RR #1 Box 488, Bunker Hill 62014, 618-585-3192. (7)

DANVILLE: More than would be expected in a city of 43,000. Area population of 190,000 served by two medium sized community hospitals. An industrial medicine specialist or a neurosurgeon would find above average opportunities for professional growth. Area offers all the advantages of a smaller city life plus easy access to major urban areas. CONTACT: Richard V. Liven-good, President, Lakeview Medical Center, 812 North Logan Avenue, Danville, 61832. (9)

ELDORADO: Busy six-doctor practice looking for G.P./F.P., General Surgeon and Ophthalmologist. \$36,000 guaranteed first year. Located in town of 5000 in scenic southern Illinois. Call Dr. Elliott O. Partridge or Dr. Denton B. Ferrell, (618) 273-3361. (7)

FAIRFIELD: Need one family practitioner and one Gyn-OB man for an established two men (F.P. & Gen. Surgeon) practice in a 6500 population community. Drawing area 20,000. Excellent salary and fringe benefits. Very well equipped hospital. Excellent local schools and junior college. University 75 miles. Good recreational facilities and churches. Contact S. W. Konarski, M.D., 101 East Center Street, Fairfield, 618-842-2187. (7)

ILLINOIS: The Illinois Dept. of Corrections has immediate openings statewide for Family Practice or General Practice Physicians interested in ambulatory care. For additional information and salary schedule contact: Cecil Patmon, 160 N. LaSalle, Chicago, 60601, 312/793-3216. (6)

JACKSONVILLE: Opportunities for family practice emergency room, dermatology, OB/GYN, orthopedic surgery. Progressive 250 bed hospital, 40-member medical staff. Prosperous community with primary service area of 60,000, two colleges, excellent schools, 35 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Area Hospital, Jacksonville, 62650 (217) 245-9541. (6)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity in solo or group practice. Contact: Carol Nafziger, Minier 61759. (309) 392-2345 or 392-2120. (6)

MUNSTER, IN.: Family, ENT, Ortho.; for large mid-west multi-specialty group. Competitive first year salary with opportunity for early partnership. No investment. Most liberal vacation and P-G allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop own practice. Send C-V to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321 (219) 836-5800. (6)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensa-

tion negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

PEORIA: Orthopedic Surgeon needed in multi-specialty clinic of 12 physicians. Excellent opportunity for the right person. Located in community of 250,000, three hospitals, school of medicine. Guaranteed first year salary plus complete fringe package. Contact: Dr. R. Martin, The Medical and Surgical Clinic, S.C. 100 N.E. Randolph, Peoria, 61606. (6)

PIKE COUNTY: Population 19,000. Two general practitioners, one general surgeon, office space available beside 82 bed, JCAH, full service hospital. Financial assistance available. Ten physicians at present. Great hunting. Gary Deer, Administrator, Illini Community Hospital, 640 West Washington, Pittsfield, AC(217) 285-2113. (6)

PITTSFIELD: Family Practitioner/General Practitioner/General Surgeon to join established practice or solo. Minimum guarantee, office space available free. 82 bed JCAH full service hospital. Great bird/duck hunting. Contact Gary Deer, Illini Community Hospital, 640 W. Washington Street, Pittsfield 62363; (217-285-2113.) (7)

SOUTHERN ILLINOIS: Opening in newly remodeled community Health Services Center located in Cairo adjacent to hospital. Target population 20,000. Six physicians, two dentists, counseling services, and outpatient lab at present. Financial assistance available. Near university and colleges. Wide range of recreational facilities. CONTACT: Steve Miller, 529 Cross St., Cairo 62914 (618) 734-4200 (8)

STERLING/ROCK FALLS: Primary Care physicians needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

SYCAMORE: Associate Desired—for July, 1980. Family practitioner to join two family physicians and internist in a newly formed group. Situated 112 kms west of Chicago in a semi-rural area. Family practice oriented hospital, with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D. (Director), 954 West State Street, Sycamore, 60178, (815) 895-9144. (9)

VALMEYER: Population 1000 with patient population of 3-4000. Scenic town on small lake. 25 miles from Belleville or Red Bud, 35 miles from St. Louis, Mo. Only physician is about to retire. Fully equipped 4 room office building for rent. Contact: H. A. Reichel, M.D., 206 W. Main, Valmeyer, IL 62295. (618) 935-2216. (6)

VANDALIA: County Hospital, serving population 25,000. Seven physicians at present. Sixty miles east of St. Louis on Interstate Highway I-70. Office space available on hospital campus. Financial assistance and deferred compensation agreements available. Contact John R. Leckrone, Administrator, Fayette County Hospital, 7th & Taylor, Vandalia 62471. (618) 283-1231. (7)

In Edema* or Hypertension* when
potassium balance is a concern...

Potassium-Sparing **DYAZIDE**®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene)
and 25 mg. of hydrochlorothiazide.

Makes Sense

In Edema

The triamterene in 'Dyazide' limits potassium loss and provides an additive diuretic effect to that of the hydrochlorothiazide component.

In Hypertension

As the hydrochlorothiazide in 'Dyazide' lowers blood pressure, the triamterene component limits potassium loss.

Serum K⁺ and BUN should be checked periodically

particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.



Before prescribing, see complete prescribing
information in SK&F Co. literature or PDR. A
brief summary follows:

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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ISMS Testimony Before The Illinois Commission To Revise And Rewrite the Public Aid Code

On February 16, 1979, ISMS president David S. Fox, M.D., presented ISMS' position before the Illinois Commission to Revise and Rewrite the Public Aid Code. This summary is intended to highlight major points.

Dr. Fox outlined ISMS' perspective early in his report. "Potentially the area of greatest concern to the State Medical Society in the administration of the Public Aid Code," he said, "is the lack of medical involvement in what we consider to be essentially medical decisions." Questions of medical necessity and retrospective audits were among examples cited. Possible aids suggested in the ISMS testimony included implementation of the MMIS (Medicaid Management Information System). This system would include prior to payment audits designed to single out statistically aberrant bills, followed by medical review of those bills.

ISMS made five specific suggestions for the Commission's consideration:

- 1) Provision of a mechanism in the code to provide for proper medical input into program development and for MEDICAL review of MEDICAL decisions—and to prohibit determinations of medical necessity by non-physicians.
- 2) A mandate in the code that the Department publish and promulgate a protocol of audit, specifying to all participating physicians and other providers what the Department may and may not do, and making reference to appropriate appeals mechanisms.
- 3) The code should prohibit the Department from financial recoupment against a provider until the Department's internal appeals mechanism has been exhausted or until such time as the provider shall agree with the Department's determination.
- 4) The code should require the Department to obtain the consent of the Public Aid patient to the release of his or her medical records.
- 5) The code should not allow the Department access to a physician's business records without due process.

In closing, the report urged a strong cooperative effort between ISMS and IDPA. "It is fitting," Dr. Fox concluded, "to observe that if we fail in this mission, the recipient—our patients—will pay the price of our failure. It is for their health and their well-being that this program must be a success." ◀

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

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Clinics for Crippled Children Listed for June

Thirty-two clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, periatric, speech and hearing examination, along with medical, social and nursing services. There will be 22 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 5 Belleville—St. Elizabeth's Hospital
 June 5 Park Ridge Cardiac—Lutheran Gen. Hosp.
 June 6 Springfield Ped-Neuro—St. John's Hosp.
 June 6 Division Cardiac—U. of I. at the Medical Center
 June 6 Hinsdale—Hinsdale Sanitarium
 June 6 Carmi—Carmi Township Hospital
 June 7 Sterling—Community General Hospital
 June 7 Effingham—St. Anthony Memorial Hospital
 June 7 Lake County Cardiac—Victory Memorial Hospital
 June 8 Chicago Heights Cardiac—St. James Hosp.
 June 11 Peoria Cardiac—St. Francis Hospital
 June 12 Peoria General—St. Francis Hospital
 June 13 Elgin (MM)—Sherman Hospital
 June 13 Joliet—St. Joseph's Hospital
 June 13 Champaign-Urbana—McKinley Hospital
 June 14 Kankakee General—St. Mary's Hospital
 June 14 Springfield General—St. John's Hospital
 June 14 West Frankfort—Union Hospital

June 14 Rockford—St. Anthony's Hospital
 June 15 Kankakee Cardiac—St. Mary's Hospital
 June 18 Maywood—Loyola Medical Center
 June 19 Decatur—Decatur Memorial Hospital
 June 19 Rock Island General—Moline Public Hosp.
 June 20 Chicago Heights General—St. James Hosp.
 June 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
 June 21 Bloomington—Mennonite Hospital
 June 22 Chicago Heights Cardiac—St. James Hosp.
 June 22 Evanston—St. Francis Hospital
 June 25 Peoria Cardiac—St. Francis Hospital
 June 26 East St. Louis—Christian Welfare Hosp.
 June 26 Peoria General—St. Francis Hospital
 June 27 Aurora—Mercy Center for Health Care Services

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Patient Care Study Announced

Ten members of the Illinois Hospital Association have been chosen for a 30 month study of "Patient Expectations and Perceptions of Hospital Care," funded by a grant from the Kellogg Foundation of Battle Creek, Michigan. According to a recent statement from the Illinois Hospital Association, the project objective is to implement an effective, feasible and reproducible procedure for including patient and family expectations and perceptions in the design of disease-specific patient care evaluation studies.

Coordinated by the Illinois Hospital Research and Educational Foundation, the program will utilize in-hospital "project study groups," composed of volunteers from the medical staff. Recently hospitalized patients and their families will be interviewed, after their individual physicians have authorized participation. Information gleaned from the interviews will be the property

of the individual participant hospital.

Hospitals chosen at the outset for participation in the project are: Mercy Hospital and Medical Center, Chicago; Richland Memorial Hospital, Olney; the Methodist Medical Center of Illinois, Peoria; Children's Hospital, Chicago; St. Joseph's Hospital, Belvidere; Carle Foundation Hospital, Urbana; Mercy Hospital, Urbana; Swedish American Hospital, Rockford; Westlake Community Hospital, Melrose Park; and Memorial Hospital, Belleville.

These hospitals were solicited after study by the Project Advisory Committee, composed of representatives of JCAH, health care organizations, third party payors and private industry. They were chosen in order to obtain a representation from hospitals of various sizes, regional settings and teaching vs. non-teaching atmospheres.

ENT SPECIALIST needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 947, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

DERMATOLOGIST needed for a large, fast growing Chicago suburb. Solo practice. Ideal for second office. Office space available in a new medical complex. Lease optional. Very favorable terms. Send resume to Box 947, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

WANTED—M.D. to write histories and do physicals. Contact: Box 946 c/o Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago 60603.

MULTISPECIALTY GROUP thirty miles southwest of Chicago seeks young family practitioner, internist, and ob-gyn man to join expanding practice. Incentive plan, profit sharing, new building. Excellent practice opportunity and schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423. (815-469-2123).

INDIANA, MICHIGAN CITY: Emergency Department Medical Director. Newly remodeled emergency department participation in community emergency medicine service. Opportunity for mature director to coordinate clinical and administrative functions. Administrative experience preferred. Great potential for development and expansion. Remuneration from \$53,000. Paid malpractice. Contact: T. P. Cooper, MD, Medical Director, 970 Executive Parkway, St. Louis, MO 63141, or call toll free (800) 325-3982, Ext. 225.

FOR SALE, LEASE OR RENT

SUITE TO LEASE for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. **STRONG Property Managers, LTD.** Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

BRYN MAWR AND KEDZIE MEDICAL-DENTAL BUILDING: common waiting room. Suite available for a medical specialist. Price: \$85,000. Please call Mr. Shapiro at IREC. (312) 649-6667.

CHICAGO AVE.—INNER CITY CLINIC. Brick two story building. Pharmacy available. Doctor retiring. \$45,000. Please call Mr. Shapiro, IREC. (312) 649-6667.

AURORA VICINITY MULTIPRACTICE MEDICAL BUILDING: recently remodeled, good patient ratio. Must be seen! Please call Mr. Shapiro, IREC. (312) 649-6667.

FOR RENT: 5 room medical suite in modern medical building; fully rented, lab, large waiting room. Free receptionist, free intercom, plenty of parking, excellent neighborhood. Looking for G.P. or internist with established practice. 87th & California. Call (312) 927-0840, ask for Carol.

MEDICAL OFFICE SUITES for rent, Lincoln-Belmont Bldg, Chicago. 600 to 715 sq. ft. avail immediately in full service, elevator active professional bldg. Call Gary Solomon (312) 334-5400.

FOR SALE, SOUTH: Medical-Dental Building 3 blocks west of Western Avenue on 63rd St.—Corner Pharmacy. Tenants occupy 9 of 12 suites. Whether interested in buying or just renting, call Marie: (312) 361-0615 before 10:00 a.m. or after 4:00 p.m.

36-YEAR-OLD GENERAL PRACTICE (medical). Available due to recent death. Excellent central location. Private parking lot. Fully equipped office, 7 rooms with bath. Medical records intact. Stimulating metropolitan area of 350,000. Many industries. 270 bed 6-year old hospital close in. Contact 1-309-786-1144.

BLUE ISLAND, ILLINOIS—Now leasing modern medical building with 6 offices, 970 square feet, adjoining home in prestigious residential area. 3 blocks to St. Francis Hospital. McNulty Realtors, 2411 New Street, Blue Island, Ill. (312) 388-3220.

FLOSSMOOR, IL.—Exec. California style ranch—2 wooded acres. 20x40 in-ground pool, 27x30 family room, 12x27 game room. 3 bdrms. Glass-enclosed patio. 5 car htd. garage. Will consider holding second mortgage or rent with option. Asking \$215,000. Call (312) 862-3100.

MEDICAL CENTER FOR RENT, complete and ready to open. 4300 sq. ft. at 2301 E. 95th St, Chicago. Lge waiting rm, 18 exam. rms, x-ray rm, central a/c & heat. Call Gary Solomon, 334-5400.

SITUATIONS WANTED

CONSIDERING STAFF ADDITIONS? Medical Assistants available throughout the state. **ROBERT MORRIS COLLEGE** has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our medical assistants are proficient in administration, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121, Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

INTERNIST, ABIM eligible, 28, Northwestern Medical School Graduate seeks employment or association with group or hospital-based practice in Chicago or suburbs. Available July 1979. Box 949, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL, 60603.

GUARANTY FUND CERTIFICATE

FOR SALE—Guaranty Fund Certificate with Illinois State Medical-Insurance Exchange. Value \$10,680.00. 15% discount. Call collect (305) 753-6699 or (305) 472-4798.

GUARANTY FUND CERTIFICATE No. 1828, ISMIE, original cost \$876.00. Coverage for Internal Medicine, Gastroenterology, contact: Zayd Kaylani, M.D., 1740 West 27th, Suite 303, Houston, TX 77008.

WANTED—Class 7, Territory 1, Guaranty Fund Certificate—Value \$10,300. Will pay 70% of original cost. No reasonable offer refused. Will combine certificates. Contact: Michael Berkson, M.D., 2416 Covert Road, Glenview, Illinois 60025 or call (312) 724-5707.

FOR SALE—Guaranty Fund Certificate. Class II. Original price \$1,160.00. Contact Dr. Stephen Lillard: 314-225-6549 or 314-645-8510. Address: 957 Beacon Woods, Manchester, MO 63011.

FOR SALE—Guaranty Fund Certificate—Amount \$772.00. Call (312) 271-0919.

FOR SALE—Guaranty Fund Certificate, Class II, original price \$1,548.00. Must sell, willing to bargain. Please call Dennis Belom, M.D. at 728-2089.

IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.

EKG

(Continued from page 289)

Answers: 1. B. 2. B.

The rhythm shows paroxysmal atrial fibrillation with a ventricular response varying from 100 to 120 beats per minute. The R-R cycles are irregular and the coarse fibrillation or "f" waves are also irregular. Coarse fibrillation waves are often associated with a successful conversion to sinus rhythm. Direct current cardioversion would not be useful here because the arrhythmia is paroxysmal. An increased dose of intravenous digitalis might slow the ventricular response further when atrial fibrillation is present. However, it

could also slow the sinus rate which is already at 60 beats per minute. Digitalis maintenance is required but the addition of oral quinidine might stabilize this patient in sinus rhythm. It could suppress the premature atrial beats which initiate the atrial fibrillation. Three common predisposing factors for atrial fibrillation are: premature atrial beats, increased vagal tone, and left atrial enlargement. Quinidine could suppress the premature atrial beats as well as reduce vagal tone by its atropinic effect. Atrial fibrillation is reported in approximately 10% of patients with an acute myocardial infarction. The prognosis of these patients seems to be related to the severity of the myocardial infarction rather than its electrocardiographic location. For further reading on this topic see Liberthson *et al.*, *American Journal of Medicine* 60:956-960, 1976. ◀

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Illinois Medical Journal

(USPS 258-160)

JUNE, 1979

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Clinics for Crippled Children Listed for July

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Clinics prove diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 24 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- July 3 Park Ridge Cardiac—Lutheran General Hospital
- July 5 Effingham—St. Anthony Memorial Hospital
- July 5 Lake County Cardiac—Victory Memorial Hospital
- July 6 Division Cardiac—U. of I. at the Medical Center
- July 9 Peoria Cardiac—St. Francis Hospital
- July 10 East St. Louis—Christian Welfare Hospital
- July 10 Quincy—St. Mary's Hospital
- July 10 Peoria General—St. Francis Hospital
- July 11 Champaign-Urbana—McKinley Hospital
- July 11 Chicago Heights General—St. James Hospital
- July 11 Hinsdale—Hinsdale Sanitarium
- July 11 Joliet—St. Joseph's Hospital
- July 12 Springfield General—St. John's Hospital
- July 12 Macomb—McDonough District Hospital
- July 12 DuQuoin—Marshall Browning Hospital
- July 13 Chicago Heights Cardiac—St. James Hospital
- July 16 Maywood—Loyola Medical Center
- July 17 Belleville—St. Elizabeth's Hospital
- July 17 Decatur—Decatur Memorial Hospital
- July 17 Rock Island General—Moline Public Hospital
- July 18 Springfield Ped-Neuro—St. John's Hospital
- July 18 Centralia—St. Mary's Hospital
- July 18 Evergreen Park—Little Company of Mary Hospital
- July 18 Carmi—Carmi Township Hospital
- July 18 Rockford—St. Anthony's Hospital
- July 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
- July 20 Kankakee Cardiac—St. Mary's Hospital
- July 23 Peoria Cardiac—St. Francis Hospital
- July 24 Alton—Alton Memorial Hospital
- July 24 Peoria General—St. Francis Hospital
- July 25 Chicago Heights General—St. James Hospital
- July 25 Elgin—Sherman Hospital
- July 26 Sterling—Community General Hospital
- July 27 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Please consult complete prescribing information, a summary of which follows:

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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The Pilloried Medical Profession

BY JULIUS KOWALSKI, M.D./PRINCETON

The following is excerpted from a talk given by the author at a dedication ceremony for the Ambulatory Care Facility at Perry Memorial Hospital in Princeton. Several of those who attended that ceremony have requested that the presentation be published in the Journal.

I would like to take this occasion to express some personal thoughts confronting the medical profession and the patient-doctor relationship.

Society is growing more complex each day and technology is avalanching upon us. Computers are talking to and building other computers, thereby compounding our social difficulties. Change is uncomfortable. It disrupts whatever little calm exists. It raises new questions and problems while old ones remain unresolved. Though we view the good old days through rose-hued glasses, none of us would really care to be mired in the past.

The previous comments are backdrop to the irksome problems, accusations, and judgment by innuendo which touch at least part of the medical profession.

In the age of miracles, it is proper to anticipate more miracles—suppression or elimination of the dreaded diseases like smallpox, organ transplants, medications which really cure. We view for the first time a whole new world of molecular biology, understanding the ecological interdependence of every plant and animal, however large or small, every grain of sand to mountain range—these all entwined as one, a continuum, with the cloud and interstellar dust.

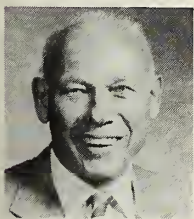
But when the magic lamp is struck and no genie appears, frustration, despair, and anger

follow. The miracle maker is a fraud. Much is expected, yes, demanded, and instantly, but little is gained. Not for the shortcomings of the physician, for he is only human, and err he does. He tries again. Another drug, a new technique, a tangential regimen. He pushes anew, because behind each doctor there is a gentle, but indomitable force, of no less than a thousand nameless apparitions who have won and who have lost in ages past, but were forever striving to understand, to help, to cure. This is the doctor's heritage for service to humanity.

The physician does more than mend torn flesh, ease the pain-wracked body, reweave the tenuous gossamer of the shattered mind. He is a counsellor, one to be trusted, the guiding light and helping hand. However, in our tumultuous kaleidoscopic society, there are some who point up the weaknesses of the medical profession. So they should. Criticism is necessary. It is the key to change.

Consider the physician's continuing medical education. Legislation is passed, demanding a minimum of formal courses or hours of study required for a given span of time in order to maintain licensure. Still, to the physician, every patient is a challenge, a problem, an education. Every newly uncovered bit of the patient's history, changing signs and symptoms, corroborative or contrary laboratory data require reinterpretation and evaluation in order to formulate a knowledgeable conclusion. Every day brings object lessons to the physician; reassessing the old, integrating the new, attempting anything to surmount the obstacles, to resolve the patient's problem.

As each doctor forges his own criteria in his daily pursuits, so medical organizations have done for their membership. An illustration: The American Academy of General Practice (now known as the American Academy of Family Physicians) was organized in 1947 upon the basic concept that each member agreed to complete 150 hours of approved post-graduate study in each three year period of certification. If he did



JULIUS M. KOWALSKI, M.D., is a board certified family practitioner affiliated with Perry Memorial Hospital in Princeton and St. Morgore's Hospital in Spring Valley, Illinois. Doctor Kowalski's extensive credits include a monthly column in the *IMJ*, "Medicine in the Outdoors," and the 1971 American Medical Sportsman of the Year Award

as the first physician to reach the North Pole. He has taught at the University of Chicago Pritzker School of Medicine as well as the UI College of Medicine in Peoria, and served as a representative on numerous civic and professional groups.

not, he alone terminated his membership.

For 30 years, physicians have participated in approved study programs without governmental coercion or threat of sanctions. This comes as a complete revelation to many outside medical circles. A common misconception has been that governmental action is necessary to force physicians to keep abreast of new developments. Not true.

Another area misunderstood by many is compensation by government, federal and state, for medical services rendered. The individual physician or the medical profession in concert has no voice in what governmental agencies will pay. Still, a contractor for a federal dam or aircraft carrier is paid on the basis of the negotiated bid. A state office building or highway is constructed at an agreed figure. However, compensation for the physician is what the government desires to pay for medical services for eligible recipients. Such discrimination does not beset any other occupational or professional group.

Whenever medical representatives attempt to negotiate with governmental agencies, word leaks out about how doctors are ghoulish money-grabbers, concerned only with their creature comforts. Indeed, there are money-grabbers and scoundrels in the medical profession, as there are in any occupational or professional group. These must be ferreted out and appropriately punished for proven wrongs. There are a few bad apples in every barrel, be they legislators, congressmen, and, yes, even presidents have feet of clay.

Discussions by the medical profession with governmental agencies about the problems of the indigent, unorganized minorities, the exploitable oppressed, historically have been met by the latter with foot-dragging and outright venomous attacks against the profession. The resulting impression is that the medical profession must make restitution for the past appalling transgressions against all humanity. Consequently, the medical profession moves slowly, withdraws, not wishing to make an issue or be accused of headline grabbing.

Here in Illinois, the medical profession sponsors or supports many health bills in each session of the General Assembly, which by all standards and available evidence, are for the public good. The Illinois State Medical Society has sponsored health legislation at municipal, county, and state levels for 138 years. Legislation to prohibit the use of lead pipe in water systems, thereby reducing plumbism, was introduced by the Illinois State Medical Society in 1918. Exam-

ination of auto drivers was introduced in 1923. It took 10 years—5 legislative sessions for final revision of the statute—to have the mandatory standard for intoxication in auto drivers reduced from 0.15% to 0.10% blood alcohol. The grist-mills grind slowly but they grind exceedingly fine.

Doctors, in their own way, are fiercely competitive, egotistical, driven to excellence. For them, only one standard exists—the very best! Every exacerbation of illness, each untoward effect, every pain of the patient, is reflected in the physician but seldom detectable. Each loss, every reversal, weighs heavily upon him. In the late, lonely hours the haunting thoughts: “Should I have done thus or so? Did I overlook an inconspicuous finding? How should I prepare to avoid a similar situation in the future?”

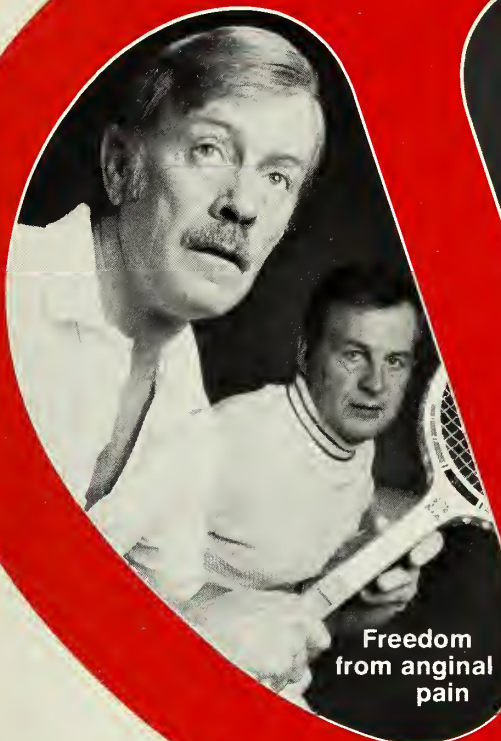
It is not a resplendent temple of healing, not gadgetry, not the secretary of Health, Education, and Welfare or the director of the Medicaid program that make for good medicine. Medical practice is an art, compassion, judgment, moral integrity, as well as excellent training. It is a person-to-person relationship under all conditions in many places despite bureaucratic disruptions. Often, it is no more or less than a facial expression, an encouraging word, the laying on of hands. It was best expressed by Robert Louis Stevenson whose entire life was a struggle with tuberculosis. He characterized the physician thus:

There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently, the artist rarely; rarer still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period and most notably exhibited the virtues of the race.

Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion tested by a hundred secrets; tact tried in a thousand embarrassments; and, what is more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sickroom and often enough, though not as often as he wishes, brings healing.

Thank you.

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from anginal
pain

Freedom
from anginal
fear



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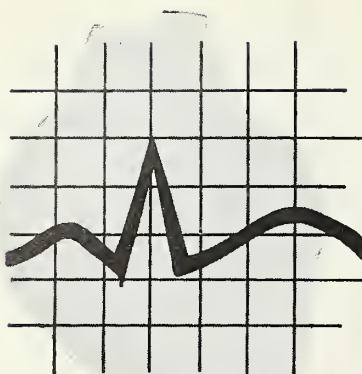
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Loyola University Stritch School of Medicine

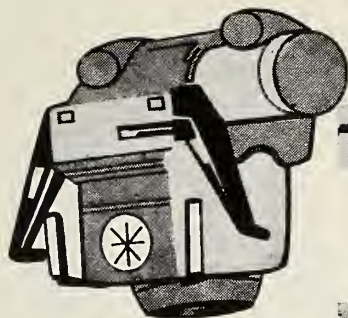
This patient is a forty-seven-year old woman who gave a history of acute rheumatic fever at age ten and a second episode at age 27. She did well until this year when she began decreasing her activities because of dyspnea on exertion. She also complained of orthopnea and pedal edema in the past three weeks. Examination of the heart demonstrated an opening snap with a loud grade 3/6 diastolic rumble and a grade 3/6 holosystolic murmur, both heard best at the apex of the heart. A chest X-ray revealed cardiomegaly of all chambers. Subsequent cardiac catheterization demonstrated severe mitral stenosis with calcifications and mild mitral regurgitation. Her cardiac index was low at 1.8 liters/minute/M². Although her pulmonary artery pressure was 40/23mmHg at rest, it rose to 70/43 with two minutes of leg raising exercise. She was recommended for mitral valve replacement and did well with the surgery. Her cardiac rhythm throughout this period was atrial fibrillation with a controlled ventricular response on Digoxin therapy. Direct current cardioversion was performed. This six lead ECG was recorded shortly after cardioversion.

1 R
2 L
3 F

Questions:

1. The ECG shows:
 - A. Paroxysmal atrial tachycardia.
 - B. Left atrial enlargement.
 - C. ST-T wave changes compatible with digitalis effect.
 - D. A period of atrioventricular (AV) dissociation.
 - E. All of the above.
2. Treatment for this cardiac problem could include:
 - A. Quinidine
 - B. Procainamide
 - C. More Digoxin.
 - D. Less Digoxin.
 - E. None of the above.

(Continued on page 412)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This is a 56-year-old patient who has complained of increasing dysphagia over the past year to the point where he is now unable to swallow solid foods.

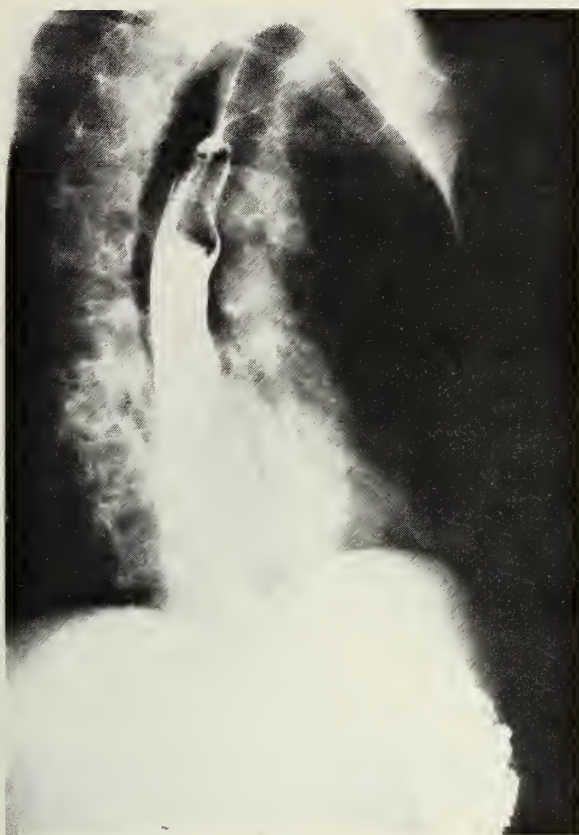


Figure 1

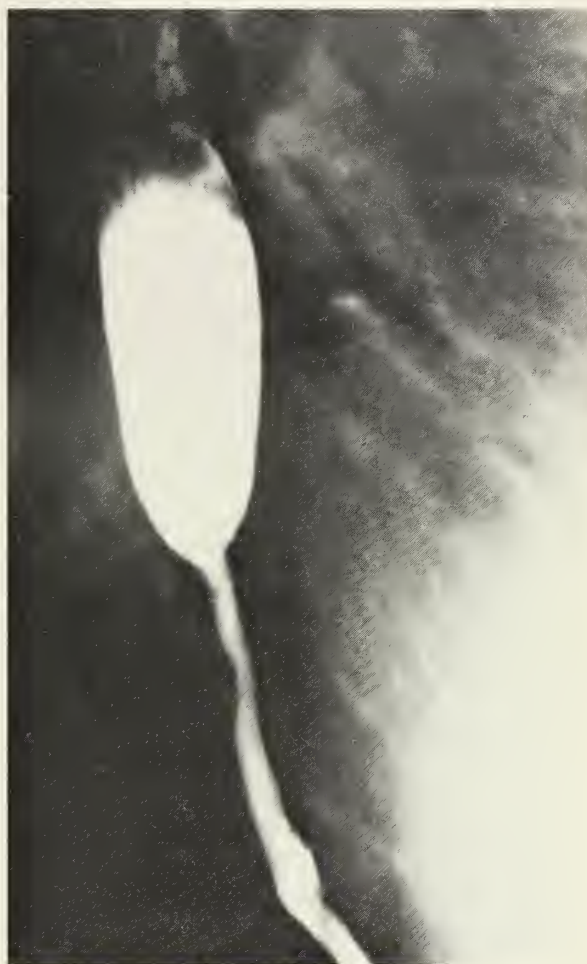


Figure 2

What's your diagnosis?

1. Carcinoma of the esophagus
2. Esophagitis
3. Caustic esophagitis
4. Barrett's esophagus

(Continued on page 387)

Oral formulation
eliminates the need for
sublingual tablets



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- human bioavailability demonstrated

for many
elderly patients
with selected
symptoms
such as...

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- mood-depression
- dizziness

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. Hydergine sublingual tablets 1 mg, containing dihydro-ergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.

Before prescribing, see package insert for full product information.

**SPECIFY "ORAL"
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Moves to Counter Litigation

Under the aegis of the Task Force on Professional Liability, ISMS has been monitoring activities to counter litigation, particularly lawsuits without merit brought against physicians, and countermoves.

A landmark case, of course, was that of Leonard Berlin, M.D., a Skokie radiologist, who won a jury

trial in Cook County Circuit Court in June, 1976. The Appellate Court overturned this finding, and the Illinois Supreme Court has refused review. Thus, a motion for *certiorari* has been filed with the U.S. Supreme Court. ISMS has filed *amici curie* briefs on behalf of Dr. Berlin to point up public policy issues involved in the

plethora of non-meritorious suits accusing physicians of professional negligence.

Monitoring of actions in other states shows that very few successes have been achieved in holding accountable those persons recklessly initiating what may be termed "nuisance suits." Some successes at lower courts have not been useful to help carve new dicta. Five states thus far reflect that Supreme Courts have not supported "countersuits" by physicians. In two states cases are currently before the respective Supreme Courts.

Here in Illinois, a physician recently was successful in a Section 41 action, showing that the allegations against him were untrue. A Kankakee judge held the plaintiff attorney liable for over \$6,900 in damages. However, five countersuits have gone to the appellate level in Illinois, four of which have denied the physician redress, while one is pending.

Claims of medical "malpractice" in 1979 (in Cook County) are at an annual rate exceeding the peak year of 1975. The first trimester was 2% above the comparable 1975 period. In addition, recent data show that while in the early 1970s about 52% of all claims were closed with no award, by 1976-77 this percentage was exceeding 65%. This might seem to indicate that an increasing number of groundless suits are being filed.

ISMS has introduced remedial legislation in every session of the General Assembly addressing this problem. Meetings and correspondence with the Illinois Supreme Court have been accomplished. Countersuits have been monitored and technical assistance provided. Discussions have been held with representatives of bar associations. In all of this, an aggressive posture has been adopted, to preserve the rights of physicians and to hold accountable those who would misuse judicial process. ◀

STATES IN WHICH COUNTERSUITS HAVE BEEN MONITORED DURING THE PERIOD 1975-1979.

STATE	No. of Countersuits	No. of Successful Countersuits or Counterclaims (State Courts)		
		Trial Court*	Appellate Court	Supreme Court
Arizona	1	0	0	0
California	25	...	0	0
Dist. of Col.	1	0	0	—
Florida	4	2	—	—
Georgia	1	1	—	—
Illinois	15	5	0	0†
Indiana	2	1	—	—
Iowa	2	0	0	—
Kentucky	9	1	—	—
Louisiana	1	0	0	—
Maryland	1	—	—	—
Michigan	2	1	1	—
Missouri	1	1	0	—
Montana	1	1	—	—
Nevada	1	1	—	—
New York	6	1	1	0
Ohio	9	0	—	—
Oregon	1	0	—	0
Pennsylvania	4	0	—	—
Tennessee	1	1	—	—
Texas	7	0	0	—
Wisconsin	4	1	—	—

Based upon information maintained by ISMS, as contained in various documents. This is not to be interpreted as inclusive of all actions in all states.

A dash indicates no decision.

* Includes pre-trial settlement, and data reflect that on file by ISMS.

† *Certiorari* filed with U.S. Supreme Court.

The Maker

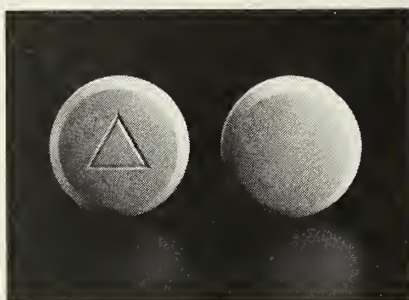
Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were



not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



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Physician Rights And Responsibilities In Illinois Epilepsy, Motor Vehicle Licensure And The Law*

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Today the automobile has become indispensable in the lives of most Americans. The license to drive, be it a right or a privilege,¹ is a valuable and necessary possession. Its loss may lead to significantly diminished earnings, unemployment or other hardship, with a consequent increase in the individual's feeling of being different. Despite this, it is clear that persons suffering from poorly controlled epileptic seizure activity² constitute a hazard to themselves and to others when driving an automobile.³ Therefore, it is appropriate that, in the case of such persons, permission to drive a motor vehicle must be strictly governed by state law.

Until about 15 years ago, state licensing administrators most often categorically denied the driving privilege to epileptic persons and others suffering from impairments affecting consciousness.⁴ Recently, however, many states have adopted less restrictive approaches in licensing epileptic drivers.⁵ Easing of restrictions is attributable, *inter alia*, to the effectiveness of anti-convulsant drugs. As a result, a large group of seizure-free epileptic persons with admirable records of driving safety have been licensed under programs which take their condition into account.⁶ Such positive licensure reform is largely a result of significant efforts by the medical profession to educate legislators and licensing administrators about the nature and consequences of epilepsy.⁷

Successes registered by the medical profession in this regard have effectively increased the na-

ture and scope of physician involvement in the licensure process. State licensing administrators have become increasingly dependent upon medical judgment and counsel.⁸ This has placed an enhanced burden upon any physician who sees epileptic patients.

The physician is confronted with the ethical and legal dilemma created by opposing duties to patient and public. In this context, a physician must balance the intense desire of a patient to obtain valid motor vehicle licensure, on one hand, against the countervailing public interest in traffic safety on the other.⁹

It is the purpose of this article to offer a resolution to this perplexing dilemma by analyzing and detailing responsibilities placed upon the Illinois physician by pertinent statutory and common law. In addition, this article will discuss the potential liabilities that a physician practicing in this area may face, as well as the legal protection which the physician can reasonably expect to receive.

The Physician's Legal Rights and Responsibilities in Diagnosis and Treatment

Fundamentally, common law places upon a physician an affirmative legal duty to carefully and completely inform an epileptic patient of the nature and attendant risks of the disease.¹⁰ Where the epilepsy is poorly controlled,¹¹ the physician is charged with the further responsibility of informing the patient that epileptic impairment poses a serious driving risk and that the patient must not drive until the prognosis changes.¹²

The most pertinent and recent judicial decision is *Freese v. Lemmon*.¹³ In that decision a pedestrian brought an action against a motorist and the motorist's physician to recover for injuries

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sustained when the motorist suffered a seizure and lost control of his automobile, striking the pedestrian.¹⁴ The defendant physician had been consulted by the defendant motorist less than three months prior to the accident for diagnosis and treatment regarding a seizure that he had recently suffered.¹⁵ The complaint in the case alleged that the physician (1) knew of the first seizure suffered by the motorist but failed to diagnose and ascertain the cause of the seizure or to learn of its reoccurrence; (2) negligently failed to employ recognized procedures to determine the cause of the first seizure; and (3) negligently failed to advise the motorist not to drive, failed to warn him of the dangers involved in driving and negligently advised him that he could drive.¹⁶ The Court concluded that a cause of action against the defendant physician existed.¹⁷ The concurring opinion specifically stated:

If plaintiffs introduce evidence on trial from which a jury could reasonably find, (1) that Dr. Dieckmann negligently advised Lemmon he could drive, (2) that in the exercise of due care Dr. Dieckmann should have expected that members of the public would thereby be put in peril, (3) that Lemmon drove in reasonable reliance upon the advice, (4) that Lemmon suffered a recurrence of his malady, (5) that Lemmon struck Lena Freese as a result, and (6) that plaintiffs were thereby damaged, then a jury case would be presented against Dr. Dieckmann¹⁸

Clearly, the *Freese* case articulates a distinct and affirmative duty on the part of the physician to warn the poorly controlled epileptic patient of the hazards of driving, even to the extent of warning strenuously against it.¹⁹ *It is essential, therefore, that the substance of all discussions with the patient relative to these issues be made a part of the patient's medical record.* An appropriate medical record entry may read as follows:

I have informed the patient that (he) (she) has _____ and that the condition is such as to raise serious doubts of (his) (her) ability to drive for the following reasons. (Set out reasons briefly). The patient understands the hazards posed by (his) (her) condition and has agreed not to drive until the prognosis changes.²⁰

The patient should be invited to initial or sign such an entry whenever possible. In some difficult cases it may be necessary or appropriate, with the patient's consent, to further discuss the patient's situation with a trusted relative who has strong positive influence on the patient in order

to help the patient voluntarily curtail driving.²¹ It should be noted, however, that such discussions should take place only after the patient's consent has been obtained.²²

Reporting Requirements

In the event a patient is unwilling to sign or initial an appropriate medical record entry signifying agreement with the physician's diagnosis and recommendations, or otherwise behaves in a manner which indicates unwillingness to heed medical advice regarding the driving impairment, the physician is confronted with the question of whether there exists some further legal obligation or public reporting duty. Unlike some states,²³ Illinois does not have a mandatory reporting statute in this regard.²⁴ The physician must therefore be guided by the exercise of proper clinical judgment. If the physician is convinced that an epileptic patient understands the nature of the malady and is acting consistent with medical advice to avoid driving, a common law duty on the part of the physician to publicly report the patient's problem is not apparent.²⁵ On the other hand, when there is reason to conclude that the patient is not heeding advice to curtail or avoid driving, or where the physician has reasonable doubts in this regard, supervening public policy considerations would effectively mandate a breach of physician-patient confidentiality and the filing of an objective, nonconclusory report of the patient's condition to the Illinois Secretary of State or the Illinois Department of Public Health Driver License Medical Advisory Board.

The legal theory underlying such a reporting duty is observed at common law and is set forth in the 1976 case of *Tarasoff v. Regents of University of California*.²⁶ There an action was brought against the University of California and its employed psychotherapists by the parents of Tatiana Tarasoff, a deceased coed. The complaint alleged, *inter alia*, that: (1) two months before the death of their daughter, Tatiana, Prosenjit Poddar, an acquaintance of the young woman, confided to his psychotherapist the intention to kill Tatiana; (2) that his psychotherapists failed to discharge their duty of reporting this confidential disclosure to the deceased woman so as to warn her of the impending danger to her life; and (3) that their failure to warn her of this threat prevented her from actively taking precautions to protect herself from harm, thereby proximately causing her demise. The Supreme Court of California supported the cause of action against the defendants, stating in

part:

Defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty . . . may call for him to warn the intended victim . . . *to notify the police or to take whatever steps are reasonably necessary under the circumstances.*²⁷

The court further stated,

"We conclude that the public policy favoring protection of the confidential character of patient-[physician] communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."²⁸

Thus, to the extent that the Illinois physician reasonably believes a poorly controlled epileptic patient may drive a motor vehicle in contravention of medical advice, a duty exists to notify the proper state licensure authorities of any existing threat so as to mitigate potential public peril.²⁹ It is important to note that in this regard the physician who voluntarily makes such a report is entitled to substantial common law and statutory protection. Immunity from liability for an alleged breach of confidence is provided by well entrenched common law doctrine embodied in the following judicial language:

A patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property . . . This is not to say that the patient enjoys an absolute right, but rather that he possesses a limited right against such disclosure, *subject to exceptions prompted by the supervening interest of society.*³⁰

This common law prescription finds support in the *Principles of Medical Ethics* published by the American Medical Association, Section 9, which states:

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or *unless it becomes necessary in order to protect the welfare of the individual or of the community.*^{30.1}

In addition to common law protections which are afforded to the physician, significant specific

statutory immunity is also provided. The Illinois Driver License Medical Review Act states:

Information submitted by medical practitioners, police officers, or members of the judiciary.

§ 13. Any qualified medical practitioner, commissioned police officer, or member of the judiciary may submit information to either the Department or the Secretary of State relative to the physical condition of a person, including suspected chronic alcoholism or habitual use of narcotics or dangerous drugs, if such condition interferes with the person's ability to operate a motor vehicle safely. Persons reporting under this Section shall enjoy the same immunities granted members of the Board under Section 12.³¹

While not specifically iterated, this section of the Statute includes epilepsy and other conditions that may result in episodic unconsciousness. The scope of immunity provided by the referenced Section 12 is hereinafter set forth:

Liability of persons for information supplied to Board or Department. § 12. No member of the Board, medical practitioner, clinic, hospital, institution for the mentally ill, both public and private, shall be liable or subject to criminal or civil action for any opinions, findings or recommendations, or for any information supplied to the Board or the Department regarding persons under review by the Department or for any reports required by this Act except for willful and wanton misconduct.³²

Taken together, Sections 12 and 13 make it logical to conclude that the qualified medical practitioner who reports information to the Secretary of State or the Department of Public Health Driver License Medical Advisory Board, relative to a patient's physical condition that interferes with ability to operate a motor vehicle safely, will be immune from civil or criminal liability except for actions or disclosures which constitute willful or wanton misconduct.³³ Thus, even a negligent disclosure would be protected.³⁴ Accordingly, the physician who unknowingly, but nevertheless incorrectly, diagnoses a patient's condition as poorly controlled epilepsy and subsequently, although negligently, reports the condition to the Secretary of State or Department of Public Health, will likely enjoy statutory immunity from civil or criminal liability for such reporting action. On the other hand, the physician who knowingly or intentionally misrepresents a patient's condition to the Secretary of State, or fails by virtue of grossly improper and inadequate practice to properly diagnose the patient's condition, which results in the

filing of an incorrect report to the Secretary of State or Department of Public Health, would be guilty of willful and wanton misconduct and would not be entitled to immunity from liability.

In addition to the common law and statutory protections which are afforded to the physician who reports driver impairment to state authorities, there is a strict confidentiality which attaches to the medical report:

506.10. *Confidential Information.* § 10. All information furnished to the Board, the results of all examinations made by the Board or at its direction, and all medical findings of the Board shall be confidential and for the sole use of the Board and the Director for the purposes set forth in this Act. No confidential information may be open to public inspection or the contents disclosed to anyone, except the Secretary of State and then only to the extent necessary to make required reports, unless so directed by a court and then only when the individual concerned has put the contents of such confidential information into issue.³⁵

The confidentiality provision, as well as the other common law and statutory reporting protections afforded to the Illinois physician, create a protective milieu in which it is clearly advisable for the physician to voluntarily report a patient's epileptic condition to the proper state authorities if there is any reasonable basis to believe that the patient may be disregarding physician directives regarding use of an automobile. Given the physician's best clinical judgment, it is important to recognize that an error in favor of reporting the patient's medical condition will confer immunity upon the physician, while an error to the contrary may well result in tort liability.³⁶

The Physician's Rights and Responsibilities in the Licensure Process

An issue of perhaps greater concern to the Illinois physician is exposure to possible civil liability in cases where a patient with controlled epilepsy seeks to obtain a driver's license on the basis of a physician's certification. In Illinois, the Secretary of State may neither renew nor issue licenses or permits to persons who are, or have been, afflicted with epilepsy.³⁷ Such licenses may only issue if "[the epileptic person furnishes] a written verified statement . . . from a competent medical specialist . . ." that he is able to safely operate a motor vehicle.³⁸ Thus, for the epileptic person to receive an Illinois motor vehicle license, precertification from a competent and well quali-

fied physician must be obtained. Obviously, the physician who receives a request for certification from an epileptic patient must consider many factors.³⁹ Generally speaking, however, the primary basis for certification will be a medical evaluation which discloses that the patient's seizures have been under control for a reasonable period of time, thus allowing prediction with reasonable medical certainty that the seizures will not recur should appropriate precautions be taken, such as continuance of medication, abstention from alcohol, etc.⁴⁰

It is important, however, that the physician's medical evaluation be made in a manner consistent with the established "standard of care."⁴¹ In Illinois, the promulgated standard of care requires the certifying physician to possess a certain degree of knowledge and skill and to apply these with the care that is ordinarily used by reasonably well-qualified physicians in similar cases.⁴²

Physicians trained in the diagnosis and treatment of epilepsy who are working with cooperative patients can usually identify those epileptic persons whose seizures are under effective control.⁴³ Epileptics have a basic seizure pattern in terms of type, frequency and severity of attack.⁴⁴ As effective treatment is administered, the seizure pattern ameliorates. From careful study and observation of an individual patient over a reasonable period of time, a physician is able to determine the effectiveness of the therapeutic program, the accuracy of the patient's reports and the patient's reliability.⁴⁵ On the basis of a total clinical impression, the physician will be reasonably capable of making a certification as to the likelihood of a patient's chances of suffering a recurrence of seizures if the patient continues to undergo treatment.⁴⁶ In *Compendium of the Epilepsies*.⁴⁷ Ernst Niedermayer, M.D. states:

In such requests for medical approval of a driver's license, EEG improvement over previous tracings is valuable objective evidence; complete EEG normalization is even more desirable but this goal may not be reached in spite of credible seizure freedom. The physician must take very seriously his decision to support (or not to support) the patient's application; he must find a firm position in the dilemma between his duties to the individual and society.⁴⁸

A favorable physician evaluation will not always be a guarantee that the state will extend the driving privilege to the epileptic person. A more objective evaluation technique is some-

Driving Agreement

Once a patient has been awarded a driver's license, the treating physician incurs a further good faith responsibility to comply with the terms of the Driving Agreement which the patient is required to execute. The text of the Agreement reads as follows:

The records of the Secretary of State, Driver Services Department, indicate you have a condition which might impair the safe operation of a motor vehicle.

The records further indicate by competent medical reports that the condition is presently adequately controlled; however, in consideration for the retention or issuance of a drivers license, I agree to the following:

1. I will remain under the care of my physician and follow exactly such treatment as prescribed.
2. I authorize my physician to report immediately any change in my condition which would impair my ability to safely operate a motor vehicle;
3. Any default in this agreement will be sufficient cause for the Secretary of State to cancel, revoke or suspend my driving privileges.
4. I further agree to notify the Secretary of State immediately if I change physicians.⁸³

In light of the above Agreement, it is incumbent upon the certifying physician to remain cognizant of the fact that the patient continues under the physician's care. In the event of any irregularities in this regard the physician must convey such information to the Secretary of State.

times used. Generally, this objective evaluation is accomplished by determining if the patient has experienced significant seizure control for specific periods of time. While the American Medical Association has recommended a two year seizure free period as a precondition to licensure,⁴⁹ several states have adopted shorter seizure free periods of six months and one year.⁵⁰ It is noted that states with a one year seizure free period have had favorable accident records for licensed epileptics.⁵¹ For this reason, certain commentators have recommended that a one year seizure free period be established as the standard for issuance of motor vehicle licenses to controlled epileptics in all states.⁵²

Illinois Prerequisites

In Illinois, however, despite prior existence of a one year seizure free period guideline,⁵³ there currently exists no statutory requirement. Illinois physicians, rather, must certify that an individual patient's operation of a motor vehicle will not be "inimical to the public safety."⁵⁴ It may be argued that the Illinois physician is therefore confronted with a more difficult task in determining whether to certify an epileptic person as medically fit to operate a motor vehicle, but there are mitigating factors. The common usage of a seizure free period of between six months and two years in

certain states,⁵⁵ medical guidelines established by the American Medical Association's Committee on Medical Aspects of Automobile Injuries and Deaths, and the description of diagnostic standards⁵⁶ in this area, which are set forth in recognized medical texts⁵⁷ and journals,⁵⁸ may be relied upon. Taken in conjunction with the physician's innate sensitivities and the exercise of sound clinical judgment, these guides aid the physician in reaching an acceptable and legally defensible⁵⁹ decision regarding the certification of an epileptic patient. Where a physician determines that a patient's licensure would not be "inimical to public safety," and the determination has been derived reasonably and in a manner consistent with the prevailing standard of care, the physician will not incur legal liability in the event of an unexpected seizure occurrence which results in a motor vehicle accident causing injury to a third party.⁶⁰

Concern develops, however, in situations where the physician's certification of medical fitness to operate a motor vehicle is or may be negligent. In these instances there are a number of substantive and procedural defenses which may be advanced to mitigate or possibly eliminate civil liability.⁶¹ Perhaps the most effective defense available to the physician is provided by Section 13 of the Driver License Medical Review Act.⁶²

This section of the Act⁶³ provides, *inter alia*, that any physician may submit information to the Department of Public Health or the Secretary of State relative to a person's physical condition if such condition interferes with ability to operate a motor vehicle safely.⁶⁴ The physical report form in which the Illinois physician is called upon to certify whether a patient is medically fit to operate a motor vehicle safely requires, among other things, that the physician also specifically indicate whether the patient has ever had epilepsy or other seizure disorders, whether the condition is uncontrollable; whether attacks of unconsciousness have occurred within the past six months;⁶⁵ whether medication is prescribed for use orally or by injection; and whether the individual takes the medication faithfully.⁶⁶ The physician must also set out complete details in relation to those questions.⁶⁷ All responses should relate objective rather than subjective data. The physical report form must be sent to the Office of the Secretary of State.⁶⁸ Information contained in this report, as well as the physician's certification as to medical fitness which appears on its face, represent a conveyance to the Secretary of State of information relative to the physical condition of a person which potentially interferes with the person's ability to operate a motor vehicle safely.⁶⁹ In this regard, Section 13 of the Driver License Medical Review Act⁷⁰ provides that persons reporting such information shall enjoy the immunities granted under Section 12⁷¹ of the Act. Section 12 provides that no person making reports to the Driver License Medical Advisory Board shall be civilly liable for any opinions, findings or recommendations given except for those which constitute willful and wanton misconduct.⁷²

It is evident that the public policy of the State of Illinois, as exemplified in the text of the above referenced statutory sections, encourages physician participation in the motor vehicle licensure process by encouraging physician reporting and certification in appropriate cases even to the extent that the information, opinions, findings or recommendations so conveyed may be negligent.⁷³

Moreover, by rule of the Office of Secretary of State describing which persons shall not be licensed or granted permits,⁷⁴ it is established that the above referenced physical report forms which are submitted to the Secretary of State are, "... for confidential use of the Secretary of State to implement the provisions of (Section) 6-103.8 and will not be otherwise available except by order of a duly constituted Court."⁷⁵ This language further supports the public policy of the

State to encourage physician participation in the motor vehicle licensure process by insuring to the physician maximum confidentiality under the law. The scope of this confidentiality provision provides significant additional procedural protection to the physician who faces a civil action based upon an allegedly negligent certification of an epileptic driver.⁷⁶

Further Protection

A further protective consideration in this context derives from the fact that the Illinois statute governing motor vehicle licensure vests in the Secretary of State the sole authority to issue licenses.⁷⁷ The recommendation or certification of a physician regarding the fitness of a particular driver, therefore, is only one factor involved.⁷⁸ It is not the physician who licenses the driver; it is the Secretary of State. In this regard, it may be argued that a civil action for injury caused by an improperly licensed epileptic driver should appropriately lie against the Secretary of State rather than the physician who was encouraged by Illinois public policy to participate in the driver license process and, by rule, confidentially certified to the Secretary of State the driver's medical fitness.⁷⁹ This argument is reinforced by the fact that Illinois statute further places upon the Secretary of State an absolute mandate to refer licensure cases to the Driver License Medical Advisory Board when there exists good cause to believe that an individual may not be able to operate a motor vehicle safely.⁸⁰ If the Secretary of State, by virtue of significant experience in this area, believes or should believe an executed physical report form to be questionable or perhaps even negligently completed and certified, the Secretary of State has a duty to refer the case to the Driver License Medical Advisory Board for further medical evaluation.⁸¹ Failure to execute this constructive responsibility is a breach of the Secretary's clearly defined statutory duty, a breach which may serve as the basis for civil action against the Secretary where an improperly licensed epileptic driver causes injury to a third party.⁸²

Summary

In light of the above discussion, it becomes evident that a number of legal defenses and statutory immunities may be advanced by a physician facing a civil action based on the theory that the physician incorrectly or negligently certified the medical fitness of an epileptic patient, thereby assisting an unqualified individual to ob-

tain a driver's license and to subsequently cause injury to a third party. Ideally, any physician confronted with such a lawsuit will readily be able to establish that the certification in question did not fall below the recognized standard of care and that there is a clear absence of negligence. Unfortunately, the physician who must deal on a day to day basis with debatable medical facts and circumstances in certifying the epileptic patient cannot always have such flawless foresight. Fearful of potential legal action, the qualified medical practitioner may be reluctant to participate in the certification process. The State has sought to minimize this reluctance and encourage broad-scale physician involvement in the driver licensure process by providing protective immunities and defenses to cooperative physicians. In light of relevant public policy considerations, it seems appropriate to conclude that available substantive and procedural defenses, and existing statutory immunities, protect the physician who certifies the medical fitness of an epileptic patient to drive from civil liability for such action in the absence of willful or wanton misconduct. *It is important to note, however, that the physician's responsibilities in these certification cases are continuing and do not cease upon licensure.*

Post-Licensure Monitoring

To the extent that the patient cooperatively remains under the care of the physician, there exists the further responsibility to carefully explain to the patient the necessity of taking appropriate medication at certain intervals, or of adhering to other instructions.⁸⁵ The physician must be certain that the patient understands the consequences of departing from an established regimen, or of other potential problems, such as driving at night, under the influence of alcohol or when tired.⁸⁶ The patient's medical record should contain information which reflects the existence of such understanding.⁸⁷

Persons who are licensed by virtue of a supporting physician's statement will be licensed for three year periods just as other Illinois drivers.⁸⁸ This will place continued responsibility on the physician to maintain and monitor the patient's medical condition. Every three years the driver's file will be reviewed by the Secretary of State.⁸⁹ It is important for the physician to be prepared to reaffirm the patient's fitness for driving at such times. In this regard, careful maintenance of the patient's medical records is quite important. This will permit the physician to set out, in reasonably objective detail, the medical data upon which the

physician's judgment of fitness is based. The efforts of the physician in this regard will provide not only continuing assistance to the patient for whom the ability to drive is essential, but will also significantly improve the physician's medical-legal posture.

Conclusion

Motor vehicle licensure of the controlled epileptic person has become a national reality in which input of the medical professional is of critical importance. It is essential that broad scale physician involvement in the licensure process be supported and encouraged so as to insure the integrity of this socially important public endeavor. Unfortunately, a set of unique duties and responsibilities attendant to the physician's involvement in this process exist which may expose the physician to civil liability. The negative inertia which stems from this increased possibility of litigation stands in opposition to the positive public objective of encouraging broad scale medical professional involvement in the licensure process. It is incumbent upon individual state legislatures to overcome this negative inertia through appropriate legislation to provide certain minimum protections to the physician who wishes to participate in this relatively new medical-legal arena.

In this regard, it seems clear that the Illinois Legislature has endeavored to meet its responsibility in encouraging physician involvement in the motor vehicle licensure process. Despite an occasional lack of clarity, numerous protections and immunities have been spelled out for the physician in the context of the Driver License Medical Review Act and the Illinois Vehicle Code as well as in State administrative rules and regulations enacted pursuant to these laws. Although existing statutory language could and probably should be amended to more clearly and specifically delineate the nature and scope of the available protections,⁹¹ it is evident that the Illinois physician who works with the epileptic patient and understands the rights and responsibilities which attend such involvement, will be entitled to substantial and significant protection when participating in good faith in the motor vehicle licensure process. ◀

References

A complete list of references for "Epilepsy, Motor Vehicle Licensure and the Law: Physician Rights and Responsibilities in Illinois," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

Acute Severe Head Injury

HAROLD C. VORIS, M.D./CHICAGO

The purpose of this article is to outline a plan of management of acute severe head injury that is based primarily on clinical signs and symptoms but takes into account the experience in various centers with constant monitoring of intracranial pressure (ICP) measurement of regional cerebral blood flow (RCBF), various cerebral metabolic values, angiography, echo-encephalography, isotope brain scans, and computerized axial tomographic (CAT) scans.

This article is not written for neurosurgeons. It is written for the doctor, usually a general or orthopedic surgeon, who may treat patients with head injuries in locations where facilities mentioned above for diagnosis and monitoring the condition of patients with severe brain injury are not available. Ideally, these patients should be transported to a neurosurgical center as soon after injury as possible. Practically, often this is not feasible. Immediate emergency care and sometimes definitive treatment may be necessary at the hospital of first admission. Definitive treatment may require some surgical intervention. The treating surgeon often is technically able to accomplish this, but has had little experience in its application.

The reader should realize that in this presentation the author is giving personal opinions and judgements which may not always be acceptable to other neurosurgeons. It is based on experience in management of a large number of patients with varying degrees of brain injury encountered over a period of more than 40 years (1934-1975). Hopefully, this article will be helpful to physicians.

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Even where there is an ample supply of neurosurgeons, many head injuries have to be treated by general surgeons and sometimes general practitioners. A neurologist may be the only available consultant under such conditions. It is the responsibility of neurosurgeons to disseminate knowledge regarding care of acute head injuries as widely as possible.

Our knowledge of the mechanisms of brain injury and intracranial hematomas has greatly increased in the last two decades. There has been considerable progress in lowering the mortality in cases of severe acute head injury. Unfortunately, with lowering of mortality there has not been an equal improvement in the quality of survival. The latter will be emphasized in this plan. It is a disservice to the patient, his family and society when heroic or extraordinary efforts result in survival in a vegetative state.

We are concerned here with patients admitted in coma or deep stupor but not obviously moribund. The latter group are deeply comatose (unresponsive to noxious stimuli) with bilateral dilated pupils that are unresponsive and fixed to light and have signs of midbrain damage. Some children in this state can be salvaged, but few adults, if any. If intracranial pressure is monitored, it will be found to approach the systolic blood pressure, with so-called perfusion pressure approaching zero. If angiography is performed cerebral perfusion will be poor. That is, visualization of cerebral blood vessels will be inadequate, with small tortuous vessels that empty poorly. Isotope angiography will show prolonged circulation time and reduced cerebral blood flow (CBF). Even if an intracranial hematoma is present, attempts for evacuation will usually be futile. This is also true of attempts to reduce ICP by other means. If these measures do save the life of the patient he will likely remain in a comatose state, and if he survives complications, he may progress to some degree of responsiveness but remain in a so-called vegetative state. A child may be an exception to the above course, but often normal mental development will not occur. When spontaneous cardiac and respiratory functions are no longer present and the pupils are dilated and fixed, it is evident that further supportive measure are useless.

Typical Patient

The patients with whom we are concerned have been described elsewhere.¹ They are comatose or deeply stuporous, may have some respiratory difficulty and blood pressure may be elevated with a slow pulse. The converse is more often true, that is, the pulse rate is elevated and the blood pressure is not elevated and may be low. They may or may not have localizing neurologic signs such as absence or reduction of reaction to noxious stimuli on one side, unilateral dilation of a pupil, differences in muscle tone on one side as compared to the other, reflex asymmetries, etc. The extent of the initial examination will depend on the patient's condition, the presence of associated injuries, and the demand for emergency procedures.

The maintenance or establishment of an adequate airway is imperative. If the patient is unconscious he should be placed on his side to permit postural drainage of mucous or vomitus and prevent its aspiration into the lungs. Aspiration of the upper respiratory tract should be carried out, and unless the patient is breathing satisfactorily, an endotracheal tube should be inserted. The presence or absence of a gag or cough reflex is helpful. Its absence indicates the need for an endotracheal tube.

Control of active hemorrhage from wounds must be attended to but repair of lacerations can wait until the patient's condition stabilizes. Ligation of vessels may be necessary before a temporary bandage is applied; usually a compressive bandage will control bleeding temporarily.

The concept of a team of specialists giving highly specialized care to the patient with multiple injuries is desirable, but the initial decisions are best made by an experienced individual who is not motivated by enthusiasm for the care of a specific organ or body system. Once the proper initial measures have been accomplished, consultations can be obtained and decisions made as to the priority of care for various injuries. Treatment of the injured brain should never take second place to other considerations. Patient survival is important, but again quality of survival must also be our goal. If cerebral function is seriously impaired, the quality of survival will never be satisfactory.

Gurdjian² reported associated injuries in 296 (33%) of 900 patients with head injury seen in one large hospital in a 12 month period. The chest, pelvis, and extremities were most often involved and accounted for 40% of these.

Tracheostomy

We have emphasized immediate establishment of an adequate airway. An endotracheal tube is a temporary measure. If it remains necessary after 12 hours, tracheostomy should be carried out. However, tracheostomy should not be performed routinely. When required, it should be done carefully, and meticulous toilet of the tracheostomy must be maintained. Its use should be terminated and the wound allowed to close as soon as possible. Finally, the use of a tracheostomy tube and an indwelling feeding tube in the esophagus should not continue for a significant length of time. If the tracheostomy tube is necessary for more than a few days, (certainly less than a week) and gastric feedings are necessary (as they will likely be under the circumstances) a gastrostomy should be substituted for the nasogastric feeding tube. Tracheo-esophageal fistula is a distressing complication and should not be allowed to occur!

Administration of O₂ is often necessary to avoid cerebral anoxia. In an emergency situation it may be given by a naso-pharyngeal catheter, or if a tracheostomy is present, a catheter may be introduced into the tracheostomy tube. Such a catheter must be small enough to avoid interference with adequate vital capacity. Where O₂ is given, adjunctive respiratory therapy is necessary to provide adequate moisture and control secretions.

If assisted respiration is necessary and the required apparatus is available, the connection between respirator and tracheostomy tube can be made by means of an adaptor. Under these circumstances, routine blood gas determinations are essential. Hypercapnia must be avoided. This author believes that assisted respiration should be a temporary measure to be discontinued if it becomes apparent that permanent impairment of cerebral function is inevitable.

Regulation of Fluids and Electrolytes

Regulation of fluids and electrolytes is essential in the brain injured patient. The circulation must not be overloaded with excess fluid. This is probably more dangerous from the standpoint of pulmonary than cerebral edema, but the latter can be important. The metabolic response to head injury is generally similar to other types of trauma but differs in some details. McLaurin³ found that after head injury there is a period of sodium retention that lasts two to three days and is followed by sodium diuresis. Mild hyponatremia

during the period of sodium retention is partly due to simultaneous water retention. Potassium remains in balance. The immediate period of water retention normally lasts about three days but may be prolonged and lead to hypotonicity of body fluids.

Excessive metabolic disturbances are essentially due to disturbed water balance. Excessive water retention leads to expansion of body water and hypernatruria. This results in hypotonicity of body fluids and is known as "cerebral salt wasting." In severe brain injury it may be due to inappropriate release of antidiuretic hormone (ADH). The symptoms of this condition (water intoxication) cannot be differentiated clinically from those of post traumatic hematoma. Therefore, water intoxication should be prevented by routine administration of salt and moderate restriction of water the first few days after head injury. The best immediate treatment for water intoxication is administration of hypertonic sodium chloride; the long term treatment is limitation of fluids.

Excessive dehydration from any mechanism that causes a persistent negative water balance leads to hyponatremia and hypernatremia. This is called "cerebral salt retention." It may be due to: (1) diabetes insipidus not compensated by extra water intake, (2) stupor or confusion that blunts normal thirst and leads to inadequate water intake, and (3) feeding of high protein mixtures by nasogastric tube. It requires 40 to 60ml. of water to excrete one gram of nitrogen, so excessive administration of protein can lead to dehydration.

Usually, the metabolic responses to head injury correct themselves. The excessive metabolic disturbances are seen in patients with severe brain injury. Certain laboratory determinations are necessary to properly manage these cases. Higgins, *et al.*,⁴ listed these with their normal values as shown in Table 1.

Prevention of serious metabolic disturbances cannot always be avoided. However, several preventive measures often are effective.

When the patient is in shock or vascular collapse at admission, he needs intravenous fluids immediately and isotonic fluids should be given sparingly in order to avoid initial water retention. If significant blood loss has occurred, transfusion of whole blood or plasma (particularly the former) should be initiated.

Patients who remain unconscious require intravenous or tube feedings. When the former are used, a solution of 2.5% glucose in 0.4% saline is more isotonic with tissue fluids. The adminis-

Table I
Characteristics of Excessive Metabolic Disturbance
Blood urea; less than 50mg/100ml
Plasma protein (total); 68mg/100ml
Nonfasting blood sugar; less than 180mg/100ml
Serum N+; 130-152 mEq/liter
Plasma chloride; 90-106 mEq/liter
Serum K+; 3.6-5.4 mEq/liter
Plasma bicarbonate; 20-30 mEq/liter
Urinary chloride (as NaCl) less than 17 mEq/liter
Urinary protein—none

tration during a 24 hour period of 1000ml. of this solution with 1000ml of Ringer's solution provides adequate fluid and electrolyte intake in most cases. Tube feeding is indicated when the patient is unconscious for more than two or three days. Feedings of 200 to 250 ml. every two hours are more physiologic than a continuous drip. Broths, fruit juices, and milk are better tolerated than many of the high caloric-high protein mixtures that are commercially available and often used because of their convenience. In most cases 2000 calories in 1500 ml. of fluid in each 24 hour period are ample for adults. Children should have proportionately smaller amounts.

Increased ICP

Increase in ICP is usually due to generalized brain swelling or cerebral edema (which may be extracellular or intracellular) or both. The differentiation of brain swelling and brain edema is theoretically interesting but difficult and not essential from a clinical standpoint. A less common cause of increased ICP is an intracranial hematoma. Recognition of this is very important. Clinically, it must be suspected when the patient remains unconscious for an hour or more after injury and especially if so-called localizing signs are present, develop, or are progressive. An adequate history of the patient's course from the moment of injury is very helpful but not always available. There is no substitute for careful continuous clinical monitoring of the patient's condition. This includes the state of consciousness, responsiveness to stimulation, pulse, respiration and blood pressure determination as well as localizing neurological signs.

Compound head wounds, especially of the penetrating variety, indicate debridement and repair as soon as the patient's condition stabilizes. Roentgenograms should precede surgical intervention. Only in this way can indriven fragments of bone and radiopaque foreign bodies be adequately identified. Debridement should be

Table 2

Plan for Management of Severe Acute Brain Injury

With the foregoing in mind, we may now outline a plan of patient management in acute severe brain injury.

1. Prompt attention to the airway if the patient has respiratory difficulty when first seen. This includes initial postural drainage, aspiration of the upper respiratory passages, and as is often necessary, endotracheal intubation.

2. Rapid evaluation of the patient's neurological condition, presence of associated injuries and decision on the priorities of treatment.

3. Debridement and repair of compound head wounds, especially of the penetrating type, as soon as the patient's condition has stabilized. This should be preceded by radiograms of the skull.

4. If the history, neurological findings, or progression of neurological signs suggest the presence of an intracranial hematoma, angiography should be carried out if such facilities are available. If no special diagnostic facilities are available, exploratory burr holes should be carried out without delay.

5. If hematoma is not suspected or exploration is negative and the patient remains unconscious or worsens, a ventricular cannula should be placed in one frontal horn. The ventricular pressure should be measured initially and fluids withdrawn as indicated. Then a subcutaneous reservoir should be attached and placed beneath the scalp to one side of the incision. A right angled connection facilitates this.

6. Removal of fluid from the ventricle may be supplemented by intravenous administration of 25% mannitol, steroids or both.

7. If the patient has surgery for hematoma, such a subcutaneous reservoir may be useful to post-operative care.

8. Intracerebral hematomas are often surrounded by devitalized brain tissue. This should be removed; if left behind it affords opportunity for development of infection. Even if it remains sterile the tissue interferes with normal healing processes. The same is true of any residual blood clot.

9. Finally, if clinical signs indicate that unsupported survival is not possible, or even if it is, but there will be permanent extensive neurological deficits, only the ordinary efforts for survival should be extended.

thorough, including all depressed bone fragments, foreign bodies, and devitalized brain tissue. The incidence of postoperative infection, both early and late, is proportional to the thoroughness of debridement.^{5,6} Occasionally, a deep-seated metallic foreign body, especially a bullet, may be left undisturbed because removal would cause undesirable damage to normal brain tissue. Such retained foreign bodies must be considered potential causes for suppuration and must also be checked radiographically for evidence of migration.

Angiography is our most important and most often avoidable method of recognizing intracranial hematomas. Echo-encephalogram may be suggestive but is not diagnostic of a hematoma. Where available, computerized scanning is not invasive and is usually (but not always)⁷ de-

pendable. It can be easily repeated where indicated. When rapid deterioration occurs, especially if associated with unilateral dilation of the pupil and progressive contra-lateral hemiparesis, no time should be lost with special diagnostic studies. Immediate surgical intervention for the presumed extradural hematoma is essential.

Surgical Drainage of Intracranial Hematomas

There is considerable difference of opinion about the surgical approach for drainage of intracranial hematomas, especially in the acute, severely injured patient. The following suggestions appear the most practical at the present time. If angiography is available and time permits, it will be diagnostic in most cases of supratentorial hematoma.^{1,8,9}

If angiography has not been done, the best initial procedure will be a burr hole in the fronto-temporal region above the anterior lobe of the ear and at the insertion of the temporal muscle. The scalp incision for this should be planned to permit a larger exposure as necessary for either craniectomy or craniotomy. It is usually best to perform craniectomy because of the relative rapidity of exposure and of later wound closure. The resultant skull defect can always be repaired at a later date if the patient survives without disabling defects. Exposure should be adequate in any case. Multiple burr holes are not usually necessary. However, the possibility of posterior fossa hematoma^{10,11} has to be considered, especially if the exploring cannula or the angiogram has revealed enlarged ventricles. In such case, a burr hole on each side should be made in the suboccipital region.

After evacuation of an extradural hematoma, all bleeding must be controlled. Arterial bleeding, especially from the middle meningeal artery, will require coagulation or ligation of the vessel. Lacerations of a large venous sinus must be controlled by primary repair or a small patch graft of fascia. Dural venous bleeding can be controlled by electrocoagulation, thin pieces of gelatin sponge or oxidized cellulose gauze. Neither of the latter should be used in excessive amounts. If there is bleeding from the inner table of the bone beyond the margins of the bony opening, the dura may be tented up against the bone by sutures to the overlying muscle or the periosteum. Drains or nonabsorbable gauze packs are to be avoided if possible.

Many methods of ICP reduction have been used in the past. The most efficacious, in order, are drainage of cerebrospinal fluid, intravenous mannitol and steroid administration. In the past cerebrospinal fluid drainage was carried out almost exclusively by the lumbar spinal route. The variable results and not insignificant risks of lumbar drainage limited the usefulness of the procedure. Now, the development of reservoirs that can be implanted subcutaneously and attached to ventricular catheters (introduced through small burr or even twist drill holes in the skull) makes ventricular drainage of cerebrospinal fluid feasible. The minimal associated risk is chiefly that of infection. Strict asepsis is essential in the performance of fluid aspiration from the subcutaneous reservoir.

Continuous ICP Monitors

I do not propose to discuss here the advan-

tages and disadvantages of the various techniques for continuous monitoring of increased intracranial pressure. Proponents have vigorously and extensively debated these.¹²⁻¹⁴ It is apparent that systems which make use of a ventricular catheter also permit ready drainage of ventricular fluid when ICP reaches dangerous levels.¹⁵

Johnston and Jennett¹² evaluated clinical usefulness of continuous ICP monitoring in 155 patients with a variety of intracranial lesions. They concluded that its value is not yet completely established. The 54 cases of head injury in their series are of interest to us. Those authors determined that ventricular drainage was the most effectual method of reducing elevated ICP and that the chief value of continuous ICP monitoring was the evaluation of treatment efficacy.

Mannitol and Steroid Therapy

The effects of intravenous mannitol and steroid therapy were studied by Miller and Leech.¹⁶ Their report concerns 61 patients in whom ICP was continuously monitored. They used the volume pressure response. This is the increase in ICP produced by the injection of one ml. of fluid into the ventricle in one second. A change in pressure of 2mm. mercury is significant. Enlarged ventricles vitiate the results of the test. Both intravenous mannitol (0.5gm. per kg. of body weight) or 26mg. of beta methasone intramuscularly, reduce the volume pressure response more than the ICP. The authors point out that the two methods operate in different ways. Mannitol operates across an intact blood brain barrier. Steroids reduce the bulk of cerebral edema areas. Obviously in some cases, the two modes of treatment may supplement each other. More recently Faupel *et al.*,¹⁷ in a double blind study found that dexamethasone, especially in high doses, produced improvement of the neurological course. It also reduced mortality to 24% as compared with 57% in the patients who did not receive steroid therapy. Unfortunately, there was an increased incidence of the so-called apalic syndrome (vegetative state).

Older methods of reduction of ICP include saline catharsis, saline enemas and diuretics. The latter have not been emphasized in the past but deserve better recognition, especially as a supplement to steroid therapy.¹⁸ The effect of intravenous hypertonic fluid is in part due to its diuretic action. It follows that excessive use of hypertonic fluids is conducive to hyponatremia and hypernatremia. ◀

References

1. Voris, H. C.: "Craniocerebral Trauma, CLINICAL NEUROLOGY, Baker, A. B. and Baker, L. H., Eds. (3 vols. plus index), Harper and Row, New York 1976. Vol. 2, Chap. 23.
2. Gurdjian, E. S.: "Prevention and Mitigation of Injuries," *Clin. Neurosurg.*, 19:43-57, 1972.
3. McLaurin, R. L.: "Some Metabolic Aspects of Head Injury," HEAD INJURY: CONFERENCE PROCEEDINGS, Caveness, W. F. and Walker, A. E., Eds., Lippincott, Philadelphia, 1966, p. 142-157.
4. Higgins, G., Lewin, W., O'Brien, J. R., and Taylor, W. H.: "Metabolic Disturbances in Head Injury," *Lancet*, 266:61-67, 1954.
5. Hagan, R. E.: "Early Complications Following Penetrating Wounds of the Brain," *J. Neurosurg.*, 34:132-141, 1971.
6. Hammon, W. M.: "Retained Intracranial Bone Fragments. Analysis of 42 Patients," *J. Neurosurg.*, 34:142-144, 1971.
7. Dublin, A. B., Rennick, J. M., and Sivalingam, S.: "Failure of Computerized Axial Tomography to Demonstrate a Chronic Subdural Hematoma," *Surg. Neurol.*, 6:23-24, 1976.
8. Subrahmanian, M. V., Rajendraprasad, G. B., and Rao, B. D.: "Bilateral Extradural Hematomas," *Brit. J. Surg.*, 62:397-400, 1975.
9. Winter, T. O. and Glockman, M. G.: "The Lateral Angiogram in the Differentiation of Extracerebral Hematomas," *Radiology*, 116:661-666, 1975.
10. Herren, R. Y. and Zeller, W. E.: "Extradural Hematomas of the Posterior Fossa," *Arch. Surg.*, 60: 953-956, 1950.
11. Miles, J. and Medlery, A. V.: "Posterior Fossa Subdural Hematoma," *J. Neurol., Neurosurg., and Psychiat.*, 37:1373-1377, 1974.
12. Johnston, I. H. and Jennett, B.: "The Place of Continuous Intracranial Pressure Monitoring in Neurosurgical Practice," *Acta Neurochir.* (Wein), 29:53-63, 1973.
13. Langfitt, T. W.: "Clinical Advances in the Management of Patients with Severe Head Injury," *Med. Coll. Vir. Quart.*, 10:167-173, 1974.
14. Yoneda, S., Matsuda, M., Shimizu, Y., Handa, J., Handa, H., Oda, F., Matsuo, K., and Taguchi, N.: "SFT—A New Device for Continuous Measurements of Intracranial Pressure," *Surg. Neurol.*, 1:13-15, 1973.
15. Lundberg N.: "Continuous Recording and Control of Ventricular Fluid Pressure in Neurosurgical Practice," ACTA PSYCHIAT. AND NEUROL., SCAND., 36: Supplement 149. Copenhagen, 1960, 193.
16. Miller, J. D. and Leech, P.: "Effects of Mannitol and Steroid Therapy on Intracranial Volume Pressure Relationships in Patients," *J. Neurosurg.*, 42: 274-281, 1975.
17. Faupel, G., Reulen, H. J., Muller, D., and Schurmann, K.: "Clinical Double Blind Study on the Effects of Dexamethasone on Severe Closed Head Injuries," ADVANCES IN NEUROSURGERY, V. 4, Eds. Wullenweber, R., Brock, M., Hamer, J., Klinger, M., and Spoerri, O. Springer Verlag, pubs., Berlin, 1977, p. 200-203.
18. Menig, G., Aulich, A., Wende, S. and Reulen, H. J.: "Resolution of Peritumoral Brain Edema Following Combination Therapy with Dexamethasone and Furosemide," ADVANCES IN NEUROSURGERY V.4, Eds. Wullenweber, R., Brock M., Hamer J., Klinger, M., and Spoeri, O. Springer Verlag, Berlin, 1977, p. 207-214.

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Psychiatric Considerations for the "Right to Pull the Plug"

BY PAUL P. DAVID, M.D./RIVERSIDE

A lot has been written about the request of the patient "to pull the plug," but in the decision of dying, many more people are involved than the patient. Each one reacts to death and dying differently. This article attempts to point out the dynamic understanding of these people and their reaction to the fact of the terminal illness and "final stage of life."

Recently the newspapers carried an article about the new California "Right to Die" law signed by Governor Edmund G. Brown, Jr., which was the first law of its kind in the nation. Governor Brown, when signing the law, expressed the feeling that "humans should not be made slaves to a machine, and extraordinary means or artificial devices do not need to prolong life beyond its natural end." The document is a very important one because similar bills have been tried by many legislatures but did not pass.

There are many articles about the right to pull the plug, but insufficient discussion of psychological aspects and involvement of the family in a decision of such magnitude.

This article will deal not only with the psychiatric aspect of terminal illness but also with understanding the family dynamics. It will consider the nurses' reaction, what the doctors feel and how the patient's relatives and friends might be involved, directly or indirectly, by the decision of the "living will."

Allowing a human being to die is a complex question for all physicians, whether or not they have been actively involved. Much of the controversy surrounding this question can be traced

to the Judeo-Christian teaching, "Thou shalt not kill." This is, of course, a difficult attitude to overcome.

In attempting to clarify this controversy, I shall try to be as objective as possible. The problem, as I see it, is two-fold:

1. Can the patient ask his physician to let him die?
2. Can a person, other than the patient, take an active or passive role in permitting that patient to die?

In considering the patient's right to have life-sustaining measures withdrawn, the following condition must first be met:

- A. The patient must be terminally ill, and recovery must be judged impossible according to present literature and knowledge.
- B. The patient should be sufficiently alert to make a decision with a sound mind, knowing the nature of his malady and its hopelessness.

Although I do not want to dwell on philosophical questions, it is important to define concepts like "total life" and "living organism." Speaking strictly as a psychiatrist, a human being is "in contact" when he is aware of things around him, is able to remember relevant events, has cognitive functioning and is able to interact emotionally with others.

Medically speaking, there are four phases of death:

- (1) sociological death (inter-personal death);
- (2) psychological death (intrapersonal death);
- (3) biological death; and
- (4) physiological death.

The implication of such a list is quite clear: if



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an organism is living biologically and physiologically only, there is no "total life." In such a case, a request for withdrawal of life-supporting procedures could be considered seriously.

Once the patient's request for death has been granted, there are four definite rules to be followed:

1. The patient should not be isolated.
2. The patient should be free of pain and be able to relate.
3. The patient should be allowed to experience his own death and should be handled with as much dignity as possible.
4. The patient should be made to feel comfortable about his beliefs in an after-life, whatever they may be. (This, of course, is a task for the clergy.)

In his book, *The Myth of Mental Illness*, Thomas Szasz argued that the suicidal patient has a right to terminate his own life and should not be forced to accept treatment against his will. Though many psychiatrists would disagree vehemently with this point of view, I feel it has some validity for those who are terminally ill. They, too, should not be denied the right to die nor should they be forced to accept additional treatment which clearly will not bring about a recovery.

Dr. Elizabeth Kuebler Ross describes the five stages of dying as denial, anger, bargaining, depression and acceptance. In her book, she points out that many professionals are afraid to tell their patients the truth about serious illness for fear that they will contemplate suicide. Of course, covert suicide is always a possibility whenever a patient requests that life-sustaining equipment be withdrawn; the patient may want to die because he is depressed.

There is evidence that terminal patients can be depressed because of depleted biogenic amines. Our current psychiatric understanding is that biogenic amines are underlying biochemical disturbances in depression and mania. In the terminally ill patient there are many changes, including electrolyte disturbances. One can speculate with certainty that the monoamines are also depleted. This alone could account for the state of depression. From a pure psychological and biological position, one can conclude that a depressed, terminally ill patient might seek rest, or the cessation of life-sustaining measures, as a form of suicide.

In this article, I do not wish to discuss any medical, moral or legal issues in connection with

the "right to pull the plug." Professionals in their respective fields should be able to discuss those issues. Much has been written about the dying patient, but I believe that the total system of communication between patient and family, doctors, nurses, other therapists and everybody surrounding him is of utmost importance. Perhaps we have oversimplified the fact in our zeal to clarify issues. Perhaps we have defined the dying patient as someone who is unique and going through certain phases. The family and persons enumerated above are also involved with the life struggle of the terminally ill patient. We doctors possibly should get more involved in preparing the family for the ultimate fate of the patient. It is difficult for the relatives to understand that the patient is terminally ill and they often request and demand some magical cure.

The Relatives

Let us examine the psychological difficulties encountered by relatives. In our society, "future-oriented" man cannot imagine the ending of his life. Death is characterized as a malicious act. Religious teachings conform to this future-oriented outlook; they teach of life, happiness, etc., afterward. Young people especially are unable to perceive that they are vulnerable, and they take risks, shirking disaster, with drugs, driving, etc.

The unconscious mind cannot distinguish between wish and deed. We view dying and actual death as shocking, and try to prevent it. The earliest civilizations, including the Egyptians and the American Indians, embalmed the body, believing it to represent the immortal soul.

The child also cannot accept the finality of death. The concept of death must be interpreted: Mother "goes on a trip," or "God has taken brother away." Adults also have a hard time with the finality of death and I believe that this is the psychological basis of why relatives often become burdensome around the dying patient. They will launch a last-ditch effort to save the patient, as if their constant intervention would somehow miraculously change the inevitability of death. Very frequently they become angry, and will accuse the medical profession of incompetence. This is the result of their own denial of the final stage of life. This is especially difficult and tragic when the dying person is a child, because parents psychologically view the child as an extension of themselves.

We, in our society, try to do whatever possible

for our children. Many times we take the blame for their illness, whether it is physical or psychological. The profession is partially to blame, because for years, they somehow made the public understand that the source of the problem stemmed from "childhood." During the terminal illness of a child, a great amount of compassion and preparation is necessary for the parents who will experience grief and guilt upon the demise of their child.

The Healing Profession

The healing profession, especially doctors and nurses, closely relate to the dying patient. Whether young or old, the experience of "losing their patient" always invokes anger and often shame and guilt. The nurse would like to change the inescapability of death, and magically tries to do whatever possible so that "he should not die while I am on duty," as if the death would be her responsibility. The experience of watching her own patient die is often traumatic. In their association with the patient's family, when confronted with misunderstanding and anger, nurses sometimes seek to relieve themselves of any responsibility. Much depends upon whether or not death came suddenly, unexpectedly, or as a result of a terminal illness. The preparation of the final hours is left up to the nurse, who somehow feels in charge, while "doing something" for the terminally ill patient. Time and re-education are needed to accept death as the "final stage of life" as Elizabeth Kuebler Ross calls it.

The death of an infant or newborn often causes feelings of fear for the life of their own children, and nurses become especially protective of them. It is not uncommon that they relate well to the parents because "I have a child of similar age." It would be psychologically unhealthy to repress these kinds of feelings. Often single nurses are prepared to accept the inevitable in a more stoic way but might be unable to tolerate the death of a patient of their parents' or grandparents' age. If they have lost a parent or grandparent, the loss of a patient of an identical age can rekindle the grief reaction.

The Administration of the Hospital

The administration is more removed, but certainly involved with a patient in the process of dying. Hospital administration is sometimes unwilling to accept the fact that people die in the hospital. In one instance we organized a "grief

group for relatives of patients who expired in the hospital, but this group was not allowed to be made public, even though it was extremely therapeutic.

Friends and Distant Relatives

In previous paragraphs I mentioned the role of relatives who feel compelled to "do something" to relieve the dying patient. Distant relatives and friends are equally concerned, and desire to share the burden of the family of the dying patient. Our American system of communication is based mostly on the telephone, but it is almost impossible to contact the wife or mother of a patient as she herself is calling to share her grief with others or is too busy to answer the innumerable phone calls.

All concerned are extremely vulnerable in trying to relate to the situation in this critical period. Frequently children of a dying parent feel remorse that they were not at bedside in the last hour; husband or wife feels guilty that they could not spend last minutes together. Often a mother and father, previously notified of a crisis, rush in to "take charge" only to abandon this attitude and sink into helpless grief.

I do not wish to describe the process of grieving (the funeral parlor and procedure of wakes) which is a custom of American society. In many cultures, different customs prevail. All were developed throughout the years to fulfill a basic need: to grieve together and allow sad feelings to ventilate. This is necessary and healthy.

The Doctors

Doctors are the closest involved with the care of the patient, whose confidence is generated by the doctor's care, therapeutic acumen and rapport. Doctors are looked upon as having the key to the life of the patient and the public, consciously or unconsciously, vests the doctor with magical power and expects magical cures. When a doctor becomes ill his patients become concerned about death, and might question his ability. If a doctor confesses to his illness, he often hears a half joking remark that "doctors are not supposed to be sick." I remember very vividly a competent internist who announced to his patients that he was retiring from practice because he had carcinoma of the liver. His patients became upset because he was not doing "something to cure himself." They would not accept the limitations of the medical profession. We are not sure if these fantasies are generated

by the doctors themselves or are handed down throughout the ages because of the origin of the medical profession as priest-healer.

When the doctor comes to the therapeutic crossroad and informs his patient that everything possible in medical science has been done for them, they invariably plead that "one can try something." The doctor often gets involved in this "game." The use of Krebiozen and Laetrile have become newsworthy items because the public has insisted on its use. This is despite the fact that in the terminally ill, it may be evident from all the signs that the patient is "not going to make it." Our present view is based upon this struggle between life and death, and doctors are the "attorneys at life" against "evil death."

I believe that many questions about the need to "pull the plug" can be answered if medicine returns to a humanistic and compassionate empathy for all concerned. If we had more time to listen, doctors would be less defensive, relatives would be less angry and the patient would be sustained in a crisis period. I hope that many of us will be mature enough to handle the question of dying, not from the standpoint that we "lost the battle," but, as Elizabeth Kuebler Ross indicated, as a "last stage of life." ◀

Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

July-August, 1979

ESSENTIALS OF CLINICAL DERMATOLOGY, July 11-13

SPECIALTY REVIEW IN PEDIATRICS, July 16-21

RADIATION SAFETY IN DIAGNOSTIC RADIOLOGY,
July 23-25

SPECIALTY REVIEW IN INTERNAL MEDICINE,
CERTIFYING, July 29-August 4 and August 5-11

GERIATRIC PSYCHIATRY, August 2-3

SPECIALTY REVIEW IN SURGERY, PART II, August 13-24

SEXUAL PROBLEMS ENCOUNTERED IN MEDICAL
PRACTICE, August 16-18

CURRENT MANAGEMENT TECHNIQUES IN RADIOLOGY,
August 17-18

SPECIALTY REVIEW IN DERMATOLOGY, August 20-24

SPECIALTY REVIEW IN ORTHOPEDICS, August 27-
September 2

For further information, course offerings and
registration, please write or call.

Registrar

**Cook County Graduate School of Medicine
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Sixth Annual Family Practice Review

Featured Speakers

William McCormack, M.D.

State Laboratory Institute

Boston, Massachusetts

Topics:

"Clinical Immunology As It Applies
to the Rheumatic Diseases"

"Update on Current Medications
Available for the Rheumatic Diseases"

J. Donald Smiley, M.D.

Dallas, Texas

Topics:

"Chlamydia, Non-Specific Urethritis"

"Urinary Tract Infection"

Featured Dinner Speaker:

Mr. Roger Tusken

Executive Director of AAFP

Topic:

"Legislative Activities of the
Academy in Washington"

September 20-21, 1979

Holiday Inn East, Springfield, Ill.

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CDC Recommended Treatment Schedules, 1978

U.S. Department of Health, Education, and Welfare
Public Health Service
Center for Disease Control
Atlanta, Georgia 30333

GONORRHEA

These recommendations were established after deliberation with these therapy consultants:

Harold C. Neu, M.D., College of Physicians and Surgeons, Columbia University; Erwin H. Braff, M.D., San Francisco Department of Public Health; Gary Cunningham, M.D., Southwestern Medical School, Dallas; King K. Holmes, M.D., Ph.D., USPHS Hospital, Seattle; Franklyn Judson, M.D., Department of Health and Hospitals, Denver; William McCormack, M.D., State Laboratory Institute, Boston; Edwin M. Mears, Jr., M.D., New England Medical Center, Boston; John D. Nelson, M.D., Southwestern Medical School, Dallas; Morton Nelson, M.D., Orange County, California; Suzanne M. Sgroi, M.D., Suffield, Conn.; Frederick Sparling, M.D., School of Medicine, The University of North Carolina, Chapel Hill; Lt. Col. Edmund C. Tramont, Walter Reed Army Medical Center, Washington, D.C.

Note: Physicians are cautioned to use no less than the recommended dosages of antibiotics.

Uncomplicated Gonococcal Infections In Men And Women

Drug Regimens of Choice

Aqueous procaine penicillin G (APPG) 4.8 million units injected intramuscularly at two sites, with 1.0 g of probenecid by mouth.

or

Tetracycline hydrochloride* 0.5 g by mouth 4 times a day for 5 days (total dosage 10.0 g). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as a single-dose therapy.

or

Ampicillin 3.5 g, or amoxicillin 3.0 g, either with 1 g probenecid by mouth. Evidence shows that these regimens are slightly less effective than the other recommended regimens.

Patients who are allergic to the penicillins or probenecid should be treated with oral tetracycline as above. Patients who cannot tolerate tetracycline may be treated with spectinomycin hydrochloride 2.0 g in one intramuscular injection.

Special Considerations

—Single-dose treatment is preferred

*Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

in patients who are unlikely to complete the multiple-dose tetracycline regimen.

—The APPG regimen is preferred in men with anorectal infection.

—Pharyngeal infection is difficult to treat; high failure rates have been reported with ampicillin and spectinomycin.

—Tetracycline treatment results in fewer cases of postgonococcal urethritis in men.

—Tetracycline may eliminate coexisting chlamydial infections in men and women.

—Patients with incubating syphilis (seronegative, without clinical signs of syphilis) are likely to be cured by all the above regimens except spectinomycin. All patients should have a serologic test for syphilis at the time of diagnosis.

—Patients with gonorrhea who also have syphilis or are established contacts to syphilis should be given additional treatment appropriate to the stage of syphilis.

Treatment of Sexual Partners

Men and women exposed to gonorrhea should be examined, cultured and treated at once with one of the regimens above.

Followup

Followup cultures should be obtained from the infected site(s) 3-7 days after completion of treatment. Cultures should be obtained from the anal canal of all women who have been treated for gonorrhea.

Treatment Failures

The patient who fails therapy with penicillin, ampicillin, amoxicillin, or tetracycline should be treated with 2.0 g of spectinomycin intramuscularly.

Most recurrent infections after treatment with the recommended schedules are due to *reinfection* and indicate a need for improved contact tracing and patient education. Since infection by penicillinase (β -lactamase)-producing *Neisseria gonorrhoeae* is a cause of treatment failure, post-treatment isolates should be tested for penicillinase production.

Not Recommended

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have NO place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

Penicillinase-Producing *Neisseria Gonorrhoeae* (PPNG)

Patients with uncomplicated PPNG infections and their sexual contacts should receive spectinomycin 2.0 g intramuscularly in a single injection. Because gonococci are very rarely resistant to spectinomycin and reinfection

is the most common cause of treatment failure, patients with positive cultures after spectinomycin therapy should be re-treated with the same dose.

A PPNG isolate that is resistant to spectinomycin may be treated with cefoxitin 2.0 g in a single intramuscular injection, with probenecid 1.0 g by mouth.

Treatment In Pregnancy

All pregnant women should have endocervical cultures for gonococci as an integral part of the prenatal care at the time of the first visit. A second culture late in the third trimester should be obtained from women at high risk for gonococcal infection.

Drug regimens of choice are APPG, ampicillin or amoxicillin, each with probenecid as described above.

Women who are allergic to penicillin or probenecid should be treated with spectinomycin.

Refer to the sections on acute

salpingitis and disseminated gonococcal infections for the treatment of these conditions during pregnancy. Tetracycline should not be used in pregnant women because of potential toxic effects for mother and fetus.

Acute Salpingitis (Pelvic Inflammatory Disease)

There are no reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis. Endocervical cultures for *N. gonorrhoeae* are essential. Therapy should be initiated immediately.

A. Hospitalization should be strongly considered in these situations:

1. Uncertain diagnosis, in which surgical emergencies such as appendicitis and ectopic pregnancy must be excluded.
2. Suspicion of pelvic abscess.
3. Severely ill patients.
4. Pregnancy.
5. Inability of the patient to follow or tolerate an outpatient regimen.
6. Failure to respond to outpatient therapy.

B. Antimicrobial Agents

Outpatients

Tetracycline* 0.5 g taken orally 4 times a day for 10 days. This regimen should not be used for pregnant patients.

or

APPG 4.8 million units intramuscularly, ampicillin 3.5 g or amoxicillin 3.0 g each with probenecid 1.0 g. Either regimen is followed by ampicillin 0.5 g or amoxicillin 0.5 g orally 4 times a day for 10 days.

Hospitalized patients

Aqueous crystalline penicillin G 20 million units given intravenously each day until improvement occurs, followed by ampicillin 0.5 g orally 4 times a day to complete 10 days of therapy.

or

Tetracycline* 0.25 g given intravenously 4 times a day until improvement occurs, followed by 0.5 g orally 4 times a day to complete 10 days of therapy. This regimen should not be used for pregnant women. The dosage may have to be adjusted if renal function is depressed.

Since optimal therapy for hospitalized patients has not been established, other antibiotics in addition to penicillin are frequently used.

C. Special Considerations

—Failure of the patient to improve on the recommended regimens does not indicate the need for stepwise additional antibiotics but requires clinical reassessment.

—The intrauterine device is a risk factor for the development of pelvic inflammatory disease. The effect of removing an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis is unknown.

—Adequate treatment of women with acute salpingitis must include examination and appropriate treatment of their sex partners because of their high prevalence of nonsymptomatic urethral infection. Failure to treat sex partners is a major cause of recurrent gonococcal salpingitis.

—Followup of patients with acute salpingitis is essential during and after treatment. All patients should be re-cultured for *N. gonorrhoeae* after treatment.

Acute Epididymitis

Acute epididymitis can be caused by *N. gonorrhoeae*, *Chlamydia* or other organisms. If gonococci are demonstrated by Gram stain or culture of urethral secretions, treatment should be:

APPG 4.8 million units, ampicillin 3.5 g or amoxicillin 3.0 g, each with probenecid 1.0 g. Either regimen is followed by ampicillin 0.5 g or amoxicillin 0.5 g orally 4 times a day for 10 days.

or

Tetracycline* 0.5 g orally 4 times a day for 10 days.

If gonococci are not demonstrated, the above tetracycline regimen should be used.

Disseminated Gonococcal Infection

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

Ampicillin 3.5 g or amoxicillin 3.0 g orally, each with probenecid 1.0 g, followed by ampicillin 0.5 g or amoxicillin 0.5 g 4 times a day orally for 7 days.

or

Tetracycline* 0.5 g orally 4 times a day for 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnant women.

or

Spectinomycin 2.0 g intramuscularly twice a day for 3 days (treatment

of choice for disseminated infections caused by PPNG).

or

Erythromycin 0.5 g orally 4 times a day for 7 days.

or

Aqueous crystalline penicillin G 10 million units intravenously per day until improvement occurs, followed by ampicillin 0.5 g 4 times a day to complete 7 days of antibiotic treatment.

B. Special Considerations

—Hospitalization is indicated in patients who may be unreliable, have

uncertain diagnosis, or have purulent joint effusions or other complications.

—Open drainage of joints other than the hip is not indicated.

—Intra-articular injection of antibiotics is unnecessary.

C. Meningitis and endocarditis caused by the gonococcus require high-dose intravenous penicillin therapy. In penicillin-allergic patients with endocarditis, desensitization and administration of penicillin is indicated; chloramphenicol may be used in penicillin-allergic patients with meningitis.

Gonococcal Infections In Pediatric Patients

With gonococcal infections in children beyond the newborn period the possibility of sexual abuse must be

considered. Genital, anal and pharyngeal cultures should be obtained from all patients before antibiotic treatment.

Appropriate cultures should be obtained from individuals who have had contact with the child.

Prevention Of Gonococcal Ophthalmia

When required by State legislation or indicated by local epidemiologic considerations, effective and acceptable regimens for prophylaxis of neonatal gonococcal ophthalmia include:

Ophthalmic ointment or drops containing tetracycline or erythromycin.

or

One percent silver nitrate solution.

Special Considerations

—Bacitracin is not recommended.

—The value of irrigation after application of silver nitrate is unknown.

Management Of Infants Born To Mothers With Gonococcal Infection

The infant born to a mother with gonorrhea is at high risk of infection and requires treatment with a single intravenous or intramuscular injection

of aqueous crystalline penicillin G 50,000 units to full-term infants or 20,000 units to low-birth-weight infants. Topical prophylaxis for neonatal

ophthalmia is not adequate treatment. Clinical illness requires additional treatment.

Neonatal Disease

Gonococcal Ophthalmia: Patients should be hospitalized and isolated for 24 hours after initiation of treatment. Untreated gonococcal ophthalmia is highly contagious. Aqueous crystalline penicillin G 50,000 units/kg/day in 2 doses intravenously should be administered for 7 days. Saline irrigation of

the eyes should be performed as needed. Topical antibiotic preparations alone are not sufficient or required when appropriate systemic antibiotic therapy is given.

Complicated Infection: Patients with arthritis and septicemia should be hospitalized and treated with aqueous

crystalline penicillin G 75,000 to 100,000 units/kg/day intravenously in 2 or 3 divided doses for 7 days. Meningitis should be treated with aqueous crystalline penicillin G 100,000 units/kg/day, divided into 3 or 4 intravenous doses, and continued for at least 10 days.

Childhood Disease

Children who weigh 100 lbs. (45 kg) or more should receive adult regimens. Children who weigh less than 100 lbs. should be treated as follows:

Uncomplicated Disease

Uncomplicated vulvovaginitis, urethritis, proctitis or pharyngitis can be treated at one visit with:

Amoxicillin 50 mg/kg orally with probenecid 25 mg/kg (maximum 1.0 g).

or

Aqueous procaine penicillin G 100,000 units/kg intramuscularly plus probenecid 25 mg/kg (maximum 1.0 g).

Special Considerations

—Topical and/or systemic estrogen

therapy are of no benefit in vulvovaginitis.

—Long-acting penicillins, such as benzathine penicillin G, are not effective.

—All patients should have followup cultures and the source of infection should be identified, examined and treated.

Gonococcal Ophthalmia

Ophthalmia in children is treated as in neonates but the dose of penicillin is increased to 100,000 units/kg/day intravenously.

Complicated Infections

Patients with peritonitis or arthritis require hospitalization and treatment with aqueous crystalline penicillin G,

100,000 units/kg/day intravenously for 7 days. Aqueous crystalline penicillin G 250,000 units/kg/day intravenously in 6 divided doses for at least 10 days is recommended for meningitis.

Allergy to Penicillins

Children who are allergic to penicillins should be treated with spectinomycin 40 mg/kg intramuscularly. Children older than 8 years may be treated with tetracycline 40 mg/kg/day orally in 4 divided doses for 5 days. For treatment of complicated disease, the alternative regimens recommended for adults may be used in appropriate pediatric dosages. ◀

Viewbox

(Continued from page 361)

DIAGNOSIS: 2. Esophagitis—As a result of tube trauma.

A careful history in this patient disclosed the fact that he had previous abdominal surgery about two years ago. At that time he had had a rather stormy post-operative course and had prolonged intubation with a nasogastric tube. (Figures 1 and 2) Indwelling tubes in the esophagus have been used for many years for decompression of the gastrointestinal tract before and after surgery, treatment of upper gastrointestinal bleeding and in cases of poisoning. Among the complications are occasional delayed stricture of the esophagus. It was originally thought that the trauma of passage of the tube caused thrombosis of submucosal veins resulting in esophageal fibrosis. However, subsequent experimental data has shown that the rich venous plexus in the esophagus makes it unlikely for a small tube to produce such significant trauma. A more likely explanation is the retention of

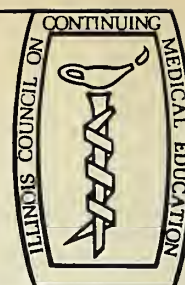
reflux above the gastroesophageal junction due to capillary action from the tube. The duration of intubation does not seem to correlate with the development of stricture. Often the initial esophagitis is asymptomatic and the first evidence of esophageal damage occurs weeks or months later with the development of a stricture. Roentgenographically the post-intubation esophagitis presents as a long smooth stricture of the distal one-third of the esophagus, indistinguishable from other peptic esophageal strictures.

Indwelling, balloon type catheters such as the Sengstaken-Blakemore tube are associated with major complications such as rupture, reflux, esophageal laceration, and respiratory obstruction in 35% of cases. An additional 10% have minor complications of varying duration.

Foley catheters placed in the esophagus post-operatively and the misplacement of endotracheal tubes may also lead to esophageal perforation. ◀

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

July

Cardiology

Cardiac Clinic

For: MD's. Lecture, July 10, 8:30 a.m., Melrose Park. Sponsor: Westlake Community Hospital, 1225 Superior St., Melrose Park, IL 60160. Reg. deadline: none. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Frank Sedlak, MD. Phone: 312-681-3000 x 210.

Dermatology

Essentials of Clinical Dermatology

For: Family Practitioners. Lecture, July 11 (3 days), Chicago. Speaker: Marshall Blankenship, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$175. Reg. limit: 100. Credit: AMA Category 1, 21 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Family Therapy

Family Systems Assessment (Introductory Course)

For: beginning family therapists. 5-day course, July 9-13, Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Reg. limit: 24. Fee: \$155. Credit: AMA Category 1, 30 hours; AAMFT Subdivision II credits. Contact: Jeanne Robinson. Phone: 312-640-7385.

Infectious Diseases

Infectious Disease Conference

For: MD's. Lecture, July 31, 8:30 a.m., Melrose Park. Speaker: Malcolm Deam, MD. Sponsor: Westlake Community Hospital, 1225 Superior St., Melrose Park, IL 60160. Reg. deadline: none. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Frank Sedlak, MD. Phone: 312-681-3000 x 210.

Medicine

Specialty Review in Internal Medicine/Certifying (Prep. for Boards)

For: Internists. Lecture, July 29 (6½ days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 600. Credit: AMA Category 1, 64 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Oncology

Tumor Board

For: MD's. Lecture, July 3 & 17, 8:30 a.m., Melrose Park. Sponsor: Westlake Community Hospital, 1225 Superior St., Melrose Park, IL 60160. Reg. deadline: none. Reg. limit: none. Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Frank Sedlak, MD. Phone: 312-681-3000 x 210.

Pediatrics

Specialty Review in Pediatrics

For: Pediatricians. Lecture, July 16 (5½ days), Chicago. Speaker: Ira DuBrow, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 200. Credit: AMA Category 1, 52 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Photographic Surgery

Photography Workshop in Plastic Surgery & Otolaryngology

For: Plastic Surgeons, Otolaryngologists. Symposium, July 26-27, Springfield. Sponsor: Biological Photographic Association & SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL 62708. Reg. limit: 60. Fee: \$145.00. Reg. deadline: 7/1. Credit: AMA Category 1, 16 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

Primary Care

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation

For: GP's, Internists. Lectures/workshops, July 27-29, Lake Geneva, Wisc. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, Colorado 80112. Fee: \$202. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Pulmonary Diseases

Respiratory Care Conference

For: MD's. Lecture, July 24, 8:30 a.m., Melrose Park. Sponsor: Westlake Community Hospital, 1225 Superior St., Melrose Park, IL 60160. Reg. deadline: none. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Frank Sedlak, MD. Phone: 312-681-3000 x 210.

Pulmonary Function Studies

The Value of Pulmonary Function Studies in Clinical Practice

For: MD's. Lecture, July 11, Chicago. Sponsor: Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. Reg. limit: 75. Reg. deadline: 7/10. Fee: none. Credit: AMA Category 1, 1 hour; AAFP, 1 hour. Contact: Fernando Villa, MD. Phone: 312-583-9000 x 331.

Radiology

Radiation Safety in Diagnostic Radiology

For: Radiologists. Lecture, July 23 (3 days), Chicago. Speaker: Theodore Fields, MS. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$200. Reg. limit: 75. Credit: AMA Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Thoracic Surgery

Thoracic Surgery Round Table

For: Thoracic Surgeons. Group discussions, 2nd Thursday of each month, Oak Brook Hyatt House, Oak Brook, IL. Sponsor: Illinois Thoracic Surgical Society, 55 E. Washington St., Chicago, IL 60602. Reg. deadline: one week before meeting. Fee: \$35. Reg. Limit: 5. Credit: AMA Category 1, 3 hours. Contact: Louis Head, MD. Phone: 312-726-3437.

August

Dermatology

Specialty Review in Dermatology

For: Dermatologists. Lecture, Aug. 20 (5 days), Chicago. Speaker: Marshall Blankenship, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Medicine

Specialty Review in Internal Medicine/Certifying (Prep. for Boards)

For: Internists. Lecture, August 5 (6½ days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 600. Credit: AMA Category 1, 64 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Orthopaedics

Specialty Review in Orthopaedics

For: Orthopaedists. Lecture, Aug. 27 (7 days), Chicago. Speaker: Peter Altner, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 350. Credit: AMA Category 1, 64 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Pediatric Dermatology

The Second International Congress of Pediatric Dermatology

For: Dermatologists, Pediatricians. Lectures/workshops, August 23-26, Chicago Marriott Hotel. Sponsor: University of Illinois at the Medical Center, Office of Cont. Educ. Services, 1855 W. Polk St., Room 144, Chicago 60612. Cosponsors: Abraham School of Medicine, Dept. of Dermatology; Int'l. Society of Pediatric Dermatology; American Society of Pediatric Dermatology; Chicago Dermatological Society. Reg. deadline: 8/1. Fee: \$205; \$175, members Int'l./Amer. Soc. of Ped. Derm. Credit: AMA Category 1, 27 hours. Contact: JoAnn Kohn. Phone: 312-996-8025.

CME VIDEO CLINICS

AMA now has available a number of video clinic "packages" consisting of a videotape, syllabus and test. Clinics meet criteria for Category 1 credit toward the Physician's Recognition Award. For information on programs available, costs, etc., contact: AMA Division on Continuing Medical Studies, 535 North Dearborn Street, Chicago, Illinois 60610.

Primary Care Medicine

Office Problems in Primary Care Medicine
For: Primary Care Physicians. Conference, Aug. 15-17, Interlaken Lodge, Lake Geneva, WI. Sponsor: Ravenswood Hospital Medical Center, Dept. of Medical Education, 4550 N. Winchester, Chicago, IL 60640. Reg. deadline: 8/1. Fee: \$90. Reg. limit: 75. Credit: AMA Category 1, 15 hours. Contact: Walter Kondratowicz, MD. Phone: 312-878-4300 x 4440.

Psychiatry/Neurology

Geriatric Psychiatry

For: Psychiatrists, Neurologists. Lecture, Aug. 2 (2 days), Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$175. Reg. limit: 75. Credit: AMA Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Radiology

Current Management Techniques in Radiology

For: Radiologists. Lecture, Aug. 17 (2 days), Chicago. Speaker: Theodore Fields, MS. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$300. Reg. limit: 75. Credit: AMA Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Rehabilitation

Electromyography and Clinical Neurophysiology

For: MD's with background in EMG. Course, August 15-18, Chicago. Sponsor: Rehabilitation Institute of Chicago/Medical Rehabilitation Research & Training Center #20: Northwestern University Medical School, Rehabilitation Institute of Chicago—Education & Training Dept., 345 E. Superior St., Chicago 60611. Cosponsor: American Academy of Physical Medicine and Rehabilitation. Speaker: Ian C. MacLean, MD. Reg. deadline: 7/30. Fee: \$195, physicians; \$90, residents. Reg. limit: 100. Credit: AMA Category 1, 26 hours. Contact: Don Olson, PhD. Phone: 312-649-6179.

Sexual Counseling

Sexual Problems Encountered in Medical Practice

For: Obstetricians, Gynecologists, Family Practitioners, Internists. Lecture, Aug. 16 (3 days), Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$175. Reg. limit: 75. Credit: AMA Category 1, 21 hours. Contact: Robert Baker, MD. Phone: 312-733-2800.

Sportsmedicine

Sportsmedicine Seminar '79

For: MD's, coaches. Symposium/lecture, Aug. 10, 4:30-10:00 p.m., Ramada Convention Center, Champaign, IL. Speaker: Johnny Orr. Sponsor: Corle Foundation Hospital, 611 W. Park, Urbana, IL 61801. Reg. deadline: 8/3. Fee: \$10. Reg. limit: none. Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Cathy Emanuel. Phone: 217-337-3327.

September

Family Medicine

Standards of Eye Care for the Primary Physician: Office and Emergency Ocular Care

For: General Practice, Emergency Medicine. 2-day seminar, Sept. 13-14, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Reg. limit: none. Fee: \$150. Credit: AMA Category 1, 14 hours. Contact: Jane Whitener. Phone: 312-996-8025.

Hypnosis

Workshop on Clinical Hypnosis

For: MD's, DDS's, Psychologists. Workshop, Sept. 13-16, St. Louis, MO. Sponsor: American Society of Clinical Hypnosis, 2400 E. Devon Ave., Suite 218, Des Plaines, IL 60018. Cosponsor: American Society of Clinical Hypnosis, Education and Research Foundation. Fee: \$225. Reg. limit: none. Credit: AMA Category 1, 24 hours; Academy of General Dentistry, 24 hours. Contact: William Hoffman, Jr. Phone: 312-297-3317.

Family Medicine/Adolescent Psychiatry

Lake County Medical/Surgical Seminar

For: MD's, DDS's, RN's, RPH's. Seminar, Sept. 26, 8:00 a.m.-1:00 p.m., Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Reg. limit: none. Fee: \$3. Reg. deadline: 9/24. Credit: AMA Category 1, 5 hours; AOA, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312-668-6461.

Government and Third Party Intervention

Between You and the Patient

For: MD's. Lecture, Sept. 19, Indian Lakes Country Club, Bloomington. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. Speaker: Frank Woolley. Reg. deadline: 9/14. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Lillian Widmer. Phone: 312-495-4050.

Internal Medicine

Clinical Refresher Course

For: General Practitioners. Lectures, Sept. 12-15, Continental Plaza, Chicago. Sponsor: Chicago College of Osteopathic Medicine, 5206 S. University, Chicago, IL 60615. Fee: \$150. Reg. limit: none. Credit: AOA, 20 hours. Contact: Marie Kowolsky. Phone: 312-947-4606.

Ophthalmology & Otolaryngology

Fall Meeting

For: Specialists in Oph. & Oto. Lectures, Sept. 15-16, Freeport. Sponsor: Illinois Society of Ophthalmology & Otolaryngology, 101 West North St., Danville, IL 61832. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: A. Reese Matteson, MD. Phone: 217-446-6410.

Otolaryngology

Annual Otolaryngologic Assembly

For: Otolaryngologists. Seminar, Sept. 16-21, The Towers Hotel, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Fee: \$400. Reg. limit: none. Credit: AMA Category 1, 42 hours. Contact: Jane Whitener. Phone: 312-996-8025.

Rehabilitation

4th Annual Management of the Spinal Cord Injured Patient

For: Multidisciplinary. Course, Sept. 17-21, Chicago. Sponsor: Rehabilitation Institute of Chicago/Medical Rehabilitation Research & Training Center #20: Northwestern University Medical School, Rehabilitation Institute of Chicago—Education & Training Dept., 345 E. Superior St., Chicago, IL 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 8/20. Fee: \$200, physicians; \$100, allied health. Reg. limit: 115. Credit: AMA Category 1, 34 hours. Contact: Don Olson, PhD. Phone: 312-649-6179.

Rehabilitation

Canadian/American Seminar: Advances in Nerve Conduction Techniques

For: Psychiatrists, Electromyographers, Neurologists. Course, Sept. 5-7, Chicago. Speaker: Paul Kaplan, MD. Sponsor: Northwestern University Medical School, Rehabilitation Institute of Chicago, Dept. of Education & Training, 345 E. Superior St., Chicago, IL 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 8/20. Fee: \$150, physicians; \$100 residents. Reg. limit: 100. Credit: AMA Category 1, 14 hours. Contact: Don Olson, PhD. Phone: 312-649-6179.

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1978-79 Annual Report

BY IRA J. ISAACSON, M.D., RPS CHAIRMAN

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Restatement of Purpose

The purpose of the Illinois State Medical Society-Resident Physician Section, (ISMS-RPS) as stated in our constitution, is to encourage and support the active participation of physicians-in-training in the state society and to provide representation of intern-resident opinions and ideals in organized medicine. In addition, the Resident Physician Section shall support the purposes of the ISMS, as stated in its constitution.

A Perspective of the RPS

The RPS has been and continues to be a small cadre of young physicians who actively seek out, or are sought out and respond favorably to, the call for participation in organized medicine. Our organization remains developmental and, hence, dynamic. The residents' original "bandwagon" was to be identified by the ISMS as a separate section and in a sense a special group. This was granted by the ISMS and from this came the constitution and bylaws for a resident physician section. After the lengthy organizational process was complete the "bandwagon" effect was perhaps lost as the participating residents began to learn and participate in the regular medical society activities. For the residents, over the past year these activities have included society committee work, new membership materials, production of a monthly residents' column in the *Illinois Medical Journal*, survey of housestaff benefits, and participation in the ISMS House of Delegates.

Additionally, the ISMS-RPS is the recognized source of resident input into the AMA-RPS. We have participated actively in the AMA-RPS activities and have been fortunate to have a member of our own governing council (Linda Hughey, M.D.) on the governing council of the AMA-RPS.

The direction that the ISMS-RPS takes will be determined by those residents that choose to participate in its future. I believe the number of active participants to be inconsequential. If the

RPS leaders make policy that the membership-at-large disagrees with, then the means for active participation by any resident member is always available.

As for specific recommendations for the year ahead:

1. I believe that, firstly, the RPS should seek active continued participation in the councils of this society. This is where the bulk of the work of the society is performed and resident opinion should be an ongoing part of the council's input.

2. Our continued participation in the ISMS House of Delegates is vital. The House of Delegates serves as our stage for visual participation. We certainly do not have the power of numbers (one vote is usually not consequential). However, delegate opinion can be swayed to our side by reasonable, cogent participation at the reference committees as well as on the floor of the House. For this reason the position of the resident delegate to ISMS remains critically important.

3. The RPS chairman should take advantage of his invitation to all the Board of Trustees meetings. This is not a highly publicized invitation, and there is not any resident vote, however a sense of resident presence could be invaluable.

4. Without a doubt the functioning of the RPS would be extremely limited if not for the strong staff support that Mr. Smithers has provided us. I believe that at times our activities place unreasonable demands on his already full schedule. Additional staffing seems reasonable and this should be made known to the Board of Trustees.

5. The ISMS-RPS participation in AMA-RPS could be broadened. Next to California, we are one of the most organized resident physician sections in the United States. The AMA house staff affairs office can serve as an invaluable reference for our activities, and the fact that we are all located in Chicago makes accessibility ideal. I would encourage full participation in each of the AMA-RPS business meetings, the next conveniently scheduled in Chicago July 21, 1979.

The AMA-RPS interim meeting in December, 1979 is scheduled for Hawaii and to encourage Illinois resident participation the RPS may wish (with the ISMS travel organization) to put together a week vacation-meeting charter package from Chicago and directed specifically at the Illinois resident members.

6. Dr. Hughey's work on the housestaff column for the *IMJ* has been superb in informing both fellow residents as well as the membership at large of our ongoing activities. This column is essential and I strongly recommend its continuation.

7. I encourage our work to obtain resident participation in the ISMS-AMA delegation. This is the one area of participation in the society from which the residents have been withheld. I firmly believe we have a place there, as both contributors and learners. Finally, I have enjoyed my term as chairman of the ISMS-RPS. I wish that I had more time to donate to medical society and RPS activities. The potential for participation is limited only by time. As I move on to a fellowship in Boston in July, I wish the remaining ISMS-RPS members well in their endeavors to keep our organization the dynamic one that I perceive it to be today.

POSITION AVAILABLE

Medical Director Psychiatrist

The Family Service & Community Mental Health Center for McHenry County is seeking an experienced, community-oriented psychiatrist to become *Medical Director*. McHenry County has been approved for federal funding from the *National Institute of Mental Health* to develop a comprehensive system of mental health services in McHenry County. Primary duties will include the development of local inpatient psychiatric beds within McHenry County. The Center is a multi-program community mental health center utilizing an interdisciplinary team approach in the delivery of services to the residents of McHenry County, a suburban county in Northern Illinois of 140,000 population, approximately 55 miles northwest of Chicago. M.D. degree, licensed to practice medicine in Illinois required. Applicant must be Board Certified in Psychiatry. Position is *full-time*. Excellent fringe benefits in a rapidly growing, expanding suburban community. Salary competitive and commensurate with experience.

Send complete resume, references, and salary requirements to:

J. Scott Campbell, ACSW
Associate Director
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Obituaries

* **Andelman, Morton B.**, Lincolnwood, died March 3, 1979, at the age of 65. Dr. Andelman was a 1942 graduate of the George Washington School of Medicine, Washington, D.C.

* **Apter, Julia**, Chicago, died April 16, 1979 at the age of 61. Dr. Apter recently held academic positions at Rush Medical College and the University of Chicago.

* **Burianek, John F.**, Berwyn, died April 22, 1979, at the age of 75. Dr. Burianek was a 1930 graduate of the Loyola-Stritch School of Medicine.

* **Collins, Robert Bruce**, Rock Island, died March 29, 1979, at the age of 70. Dr. Collins was a 1934 graduate of the University of Illinois.

** **Crossman, Roy A.**, Highland Park, died March 7, 1979, at the age of 84. Dr. Crossman was a 1926 graduate of Rush Medical College.

** **Goodwin, Grover C.**, Rankin, died March 16, 1979, at the age of 84. Dr. Goodwin was a 1916 graduate of the Loyola University Stritch School of Medicine.

** **Gotlieb, Philip**, Florida, died May 1, 1979, at the age of 89. Dr. Gotlieb was a 1923 graduate of the University of Minnesota Medical School.

* **Heidgen, Martin F.**, Elmhurst, died January 22, 1979, at the age of 74.

* **Jacey, V. J.**, Palatine, died April 3, 1979, at the age of 70. Dr. Jacey was a 1937 graduate of Chicago Medical School.

* **Kukral, John C.**, Riverdale, died April 7, 1979, at the age of 52. Dr. Kukral was a professor at Rush-Presbyterian-St. Luke's Medical Center, and a graduate of the University of Illinois Medical School.

* **Kunstadter, Ralph H.**, Chicago, died March 28, 1979, at the age of 74. Dr. Kunstadter was a 1930 graduate of the University of Illinois.

Levenson, Norman I., Pennsylvania, died April 29, 1979.

Lewis, Ralston, Petersburg, died April 10, 1979, at the age of 95.

** **Marcusson, William B., Jr.**, River Forest, died February 10, 1979 at the age of 83. Dr. Marcusson was a 1925 graduate of the University of Illinois. He had served on the staff of West Suburban Hospital.

* **Miodus, Marion D.**, Oblong, died April 8, 1979, at the age of 59. He was a 1949 graduate of the University of Illinois. During his medical career Dr. Miodus served as Crawford County Coroner and president of that county's medical society.

** **Momigliano, Emanuele**, Chicago, died February 24, 1979 at the age of 79. He was a 1923 graduate of Torino Medical School in Italy.

** **Quinn, Everett Ray**, East Alton, died at the age of 76. Dr. Quinn practiced at Wood River Hospital where he was the first chief of staff. The Wood River Township Medical Library was named in his honor.

* **Raim, William**, Oak Park, died April 14, 1979, at the age of 86. Dr. Raim was a 1916 graduate of the University of Illinois, Chicago.

** **Reichel, Hans**, Valmeyer, died April 6, 1979, at the age of 78. He was a 1925 graduate of the University of Vienna, Austria. Dr. Reichel was a past staff president of St. Clement Hospital.

Scott, A. C., Massachusetts, died April 21, 1979. Dr. Scott is a former Evansville physician.

* **Scott, Lawrence D.**, Chicago, died April 15, 1979, at the age of 61. Dr. Scott was a 1933 graduate of Meharry University.

** **Sloan, Howard P.**, California, died at the age of 77. Dr. Sloan was a 1926 graduate of the Loyola Stritch School of Medicine. He was a former medical director for Bloomington Civil Defense and former vice chairman of the American Cancer Society, Illinois Division. During his medical career he was active on the staffs of St. Joseph's Hospital Medical Center and Mennonite Hospital.

** **Smialek, John Martin**, Norwood Park, died March 28, 1979, at the age of 71. Dr. Smialek was a 1937 graduate of Chicago Medical School.

** **Stansell, Gilbert Bradshaw**, Rockford, died May 20, 1979 at the age of 62. He is a 1943 graduate of Northwestern University Medical School. Former director of the laboratory at St. Anthony Hospital. Dr. Stansell had also served as a board member for the Rockford Rape Counseling Center and had taught at the Ohio Medical College for 14 years.

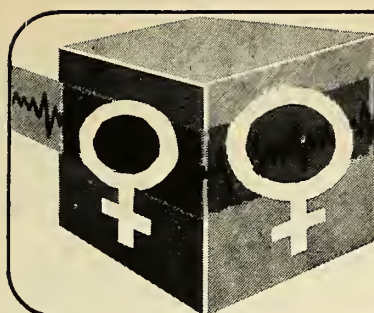
* **Steiner, Louis M.**, Chicago, died May 2, 1979, at the age of 72. A 1933 graduate of the University of Illinois Medical School, Dr. Steiner was a former medical staff president at Edgewater Hospital.

** **Telford, Elbridge Wright**, DeKalb, died March 24, 1979, at the age of 77. Dr. Telford was a 1926 graduate of Northwestern University.

Veseen, Leslie L., Chicago, died March 2, 1979. Dr. Veseen was past president of the Chicago Urological Society.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club



of the ISMS auxiliary



Preventive Medicine is Catching

BY MRS. R. S. HOOVER, ISMSA
PRESIDENT

"Preventive medicine is where the action is," wrote one of our Illinois State Medical Auxiliary past-presidents in answer to a questionnaire this past year. She put into words the focus of the ISMS Auxiliary for the 1979-1980 year. Our efforts will be mainly in the area of health education, with emphasis on developing and maintaining a healthful lifestyle.

According to a survey conducted for the American Hospital Association, consumers are interested in health education, but have little knowledge of available programs. About 60% of respondents in ten cities said they were unaware of any health education and information programs. Of the remaining 40%, half said that they had participated in health programs and half of these said that the programs had resulted in changed health practices. A major finding of the survey was that a balanced diet and participation in some form of regular exercise were listed as the greatest contribution to maintain health. The survey also found that responders most desired education programs dealing with stress reduction and home safety.

All over the United States we are seeing a new public reaction. Americans are doing something about keeping fit—exercising, watching waistlines, weighing the impacts of tobacco and alcohol, driving more sensibly—respecting their own bodies. Hopefully, this change of attitude

will be reflected in a decreased cost of health care, not only in cash dollars, but perhaps in lower taxes (less costly health programs) and less government control.

The climate is changing! The American public is suddenly health conscious. Having a healthful lifestyle is chic! No longer is a health buff a berry and nut eater living somewhere in the wilds. Literally hundreds of books on diet, fitness, exercise, and stress control are being published monthly. The health consciousness of the whole country has been raised.

It seems that current trends in economics, politics, medical research and social patterns are saying that prevention is the best medicine and development of a healthful lifestyle the necessary way to longevity. We are what we eat and drink, how we exercise and relax. From a five year survey of 7,000 adults, seven simple personal health habits are recognized as "seven good habits your doctor wishes you had." These are:

- Three meals a day without snacking
- Moderate exercise two or three times a week
- Seven or eight hours of sleep a night
- No smoking
- Immunization
- Moderate weight
- Moderation of alcohol intake

If the medical community follows these rules, couldn't we be excellent personal examples to patients? (Also, adhering to these rules costs very little.)

Findings of a Harris poll last fall stated that although most people *said* that they would take advice on nutrition, exercise and smoking from their personal physician, it is almost never given. This is hard to believe. William L. Carlyon, director of the AMA Department of Health Education, feels differently. He notes that more and more medical practitioners, even overworked ones, are promoting the values of prevention for patients and communities. "Health education is catching on like crazy," he says.

The Auxiliary Project Bank Catalogue describes no less than 147 programs in health education—ranging from the painting of immunization message hopscotch courts on school playgrounds to hypertension screening in shopping centers. In one year, auxiliary members across the nation worked on 829 immunization campaigns, 129 safety projects and 359 screening programs for vision, hearing and other physical problems—all prime topics in preventive medi-

cine.

So promoting preventive medicine programs is nothing new for the auxiliary. In the last few years, Illinois auxiliaries have promoted programs on immunization, CPR, nutrition, drug and alcohol abuse, water safety, automobile and bike safety, to name but a few.

This year the Illinois Auxiliary will inaugurate its Health Projects Team. Headed by our Health Projects Chairman, Vice President Mrs. Harold Keegan, our team will include Mrs. Robert Richardson, Peoria, Health Education; Mrs. James Gwaltney, Quincy, Community Health; Mrs. Irwin Blumfield, Alton, Safety; Mrs. Donald Rager, Peoria, Family Health; Mrs. Gamil Arida, Joliet, Project Bank and Program; and Mrs. Donald Hinderliter, Rochelle, Advisor. Our team will design and explain preventive medicine/healthful lifestyle projects for Illinois county auxiliaries. Team members also are available to give programs upon request of the individual county auxiliary. They have chosen the theme, "Follow the Yellow Brick Road to Health and Happiness" for this year. Call them; they will come! ◀

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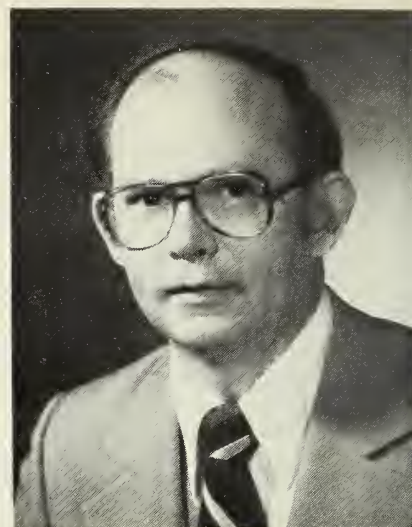
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Privileges And Responsibilities

The following is Dr. Seward's inaugural address, presented May 9, before the ISMS House of Delegates.



Being a physician is a gift. As with most gifts, it carries a duty, and also a responsibility to control and defend.

Physicians occupy a unique position in today's society. Many people place us on a professional pedestal, and others—some envious of the privileges we enjoy—are shrill advocates of regulation and control of our profession.

When we answer these detractors, we adopt identical frames of reference, frames of little understanding and total ignorance concerning the practice of medicine.

We are so accustomed to justifying our privileges that we neglect to emphasize our responsibilities. We are so accustomed to discussing what is wrong with American medicine that we ignore what is right.

What makes a physician? Caring for pain and suffering. The answer may be trite. However, that elementary principle is the common denominator between the anxious voice on the telephone at 2:00 a.m. . . . the 100th suture of the evening in the emergency room . . . the dispensation of vaccine in the office . . . a newborn's first gasps of life . . . and a myriad of other events. These are the elements of our unique life.

Caring for pain and suffering of fellow human beings is our privilege and responsibility. Being a physician is more than a job. It is a way of life.

The M.D. degree marks us with a special responsibility. We are acutely aware of this responsibility. We are angered by it, rewarded by it and respected by it.

We must never view medicine's privileges as reasons for shouldering medicine's responsibilities. Medicine's responsibilities should be viewed as part of the ongoing tradition of service. We owe no apologies for the performance of American medicine. Physicians stand atop a tidal wave of progress. Medical care has advanced farther in the past 70 years than in the previous 700. It has moved from the stone age to the laser age in a remarkably short time span, virtually eradicating diseases which routinely struck down patients 50 years ago.

Are you ashamed of success? Should you feel compelled to dwell on what is wrong with our profession? I say *no*. I am proud of my profession. I am proud of our tradition of service and uncompromising high standard of care.

Ralph Waldo Emerson said: "We can see well into the past, we can guess shrewdly into the future, but that which is rolled up and muffled in imperturbable folds is today."

Today is here. Today we must decide and plan for the future.

Emerson also observed: "The eloquent man is he who is no beautiful speaker, but who is inwardly and desperately drunk with a certain belief." I must confess that I am drunk with the belief that our standards are high and that physicians accept their responsibilities.

The Illinois State Medical Society has been instrumental in the development and preservation of

A handwritten signature in dark ink, reading "John Seward" with a stylized flourish at the end.

P. John Seward, M.D., President

high standards of care . . . programs to educate the public about health care . . . and countless activities that benefit patients and society as a whole.

Organized medicine is a force committed to helping all members of society, not just physicians. However, through our innocence or apathy we have allowed ourselves to be portrayed by government as greedy, unprincipled "technocrats".

We have allowed ourselves to be placed on the defensive, apologizing for our successes to those intent on controlling us.

Plato said: "No physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of his patient, for a true physician is also a ruler having a human body as his subject."

Be proud of our profession and carry our commitments proudly! Involve yourself in the profession's activities and aspirations for the future.

Our profession is not perfect. No segment of society can claim perfection. But we have dwelled for too long on what is wrong. It is time to reflect on what is right and how it best might be preserved, nurtured and improved.

Orwell's 1984 may be more than just a work of fiction. It could be tomorrow's nightmare. With 1984 just around the corner, it has become fashionable to construct personal Orwellian scenarios. My Orwellian fantasy conjures up the loss of the precious freedom we must have to effectively treat our patients. That freedom is difficult to describe, but nonetheless real. It is the freedom (the knowledge) that no institution, third party or government should stand between patient and physician.

Peer into the future as I look at this freedom. The possibility exists that some day:

- All physicians will be government employees;
- Patients with non-emergent conditions will wait years for treatment;
- Medical care will be dispensed like gasoline—purchased with the strength of a ration card;
- Technology will stagnate—either unused because of its expense, or never invented because of governmental red tape.
- Health systems agencies' well-intentioned—but ill-conceived—plans will aggravate all the problems by promoting politically-attractive—but medically-unworkable and socially unacceptable—solutions; and
- A bureaucracy will develop a regulation forbidding physicians to treat any patient privately.

The physicians of America will look at the decline and fall of a once great health care system and ask "what happened?"

This glimpse into the future is frightening because it could easily come true. In fact, some say it is inevitable. We hear a lot about what I call the "inevitability doctrine." However, inevitability is not an established fact. It is only a perception. We must create a different perception.

We must become activists if we hope to shape a more attractive future for our profession. What can the individual physician do? The initial response might be "very little." Nothing could be further from the truth! Much can be accomplished through participation in organized medicine. And the structure of the Illinois State Medical Society affords a wide range of opportunities for those willing to participate.

Each of us has a debt to pay. We have a responsibility to return the benefits of this unique perspective to the profession. We inherited this debt from our predecessors and we owe it to those who will follow us. We are part of a broad continuum. Those who come after us will benefit from what we accomplish. Our gift—our profession—derives not only from our abilities, but also from the sacrifices of those who preceded us. It is time for us to sacrifice.

We must defend the privilege and ability to treat patients without apology or servility to the political whims of the moment. Coersion is not a creative force. No idea, discovery, invention, insight or intuitive flash ever issued from a coercive edict.

Dante said: "The hottest place in hell is reserved for those who in times of moral crisis maintained their neutrality."

- It is time to stop being neutral and lukewarm about medicine and its activities.
- It is time to turn the tables and put the regulators and bureaucrats on the

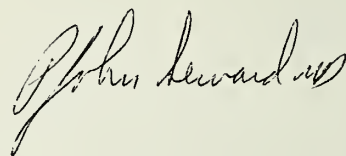
defensive by insisting that they spell out, with absolute specificity, their alternative approaches to health care.

- It is time to recognize the necessity and responsibility of meaningful involvement in our county, state and national medical societies.
- It is time to realize that our failure to arouse medicine from its slumber has horrendous and perfidious consequences for patient care.
- It is time to stand fast against further encroachments on our ability to provide high quality care. We must make that stand not just in our offices and the scrub room but on HSA boards, on county, state and national committees . . . in testimony before legislative bodies, in political campaigns . . . at civic clubs and as teachers. Anywhere we can aid the cause of our profession.

Above all, it is time to take new pride in our calling. The pride of the dedicated professional is knowing that he or she is a member of a unique profession.

We must meet the grave challenge facing the medical profession today . . . persevere and preserve the principles of our profession . . . and cede this privilege and responsibility to the next generation untarnished.

To paraphrase the words spoken by Winston Churchill after the fall of Dunkirk: "Let us therefore brace ourselves to our duties, and so bear ourselves that" if the Illinois State Medical Society lasts for a thousand years, "men will still say, this was its finest hour." ◀



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Doctor's News

PEDIATRICIAN OF THE YEAR NAMED—The Illinois Chapter, American Academy of Pediatrics, chose Richard E. Dukes, M.D., Urbana to receive the "Pediatrician of the Year," award. The award, given in memory of Albert Pisani, M.D., is presented annually to an outstanding pediatrician for dedicated service to medicine, the community and the health and well-being of the children of Illinois.

MEDICAL OFFICE MANAGEMENT INSTITUTE WORKSHOPS ANNOUNCED—Conomikes, Inc., national productivity consultants to health professionals, has announced that their annual workshops for medical office managers and personnel will be held in Chicago July 31-August 3, 1979. The four day workshops, designed for personnel in medical practices ranging from solo practice to six-physician groups, consist of two day discussions on personnel management, and one day each to consider patient flow and financial management problems. Cost for attending all four sessions will be \$270. For further information, write Conomikes Associates, Inc., 4270 Promenade Way, Suite 122, Marina del Rey, CA 90291, or telephone (800) 421-6512.

HOSPITAL CME OPPORTUNITY—The Ohio Medical Education Network (OMEN) has announced that memberships are available for the 1979-80 program schedule. OMEN is a telephone network for hospital staff, supplying CME lectures from Ohio State University. One hour of AMA Category 1 credit is available for each of 30 weekly programs, which are broadcast for one hour. Fifteen Illinois hospitals currently hold membership in OMEN.

Programs are conducted for small group seminars, and consist of lecture and discussion through closed circuit amplified telephone. Cost to interested hospitals is determined on a sliding scale, based upon bed capacity. The deadline for membership applications is July 19, 1979. For further information on specific lectures and costs, contact Arthur Bartfray, CCME, A-352 Starling-Loving, 320 W. 10th Ave., Columbus, OH 43210.

ORGAN TRANSPLANTATION HOTLINE—The Association of Illinois Transplant Surgeons, in cooperation with the Chicago Hospital Council, has promulgated a *Protocol for Physician Participation in Procurement of Organs for Transplantation*. The Protocol reviews criteria for organ donors, and the physician's role in the procedure, as provided by the Illinois Anatomical Gift Act. Also available are more detailed, *Guidelines and Procedures for Organ Donation and Transplantation*. Interested physicians may contact them at 127 N. Dearborn, Suite 1338, Chicago 60602 or call the 24-hour hotline, (312) 263-3655. Information may also be obtained from the Illinois Eye Bank of the Illinois Society for the Prevention of Blindness, 53 W. Jackson Blvd., Room 1432, Chicago 60604. Their 24-hour hotline number is (312) 922-8710.

AMA NEGOTIATIONS SEMINARS ANNOUNCED—Two seminars will be sponsored by the American Medical Association Department of Negotiations for physicians interested in the "Dynamics of Conflict Resolution." The first, August 10-11, in Denver, Colorado, is intended for salaried physicians. The second, August 27-September 1 in Portsmouth, New Hampshire, is a combined seminar to enhance physician skills in medical staff leadership as well as conflict resolution. Cost to AMA members is \$150 for the first and \$450 for the second program. For further information, contact the AMA Department of Negotiations, 535 N. Dearborn St., Chicago, IL 60610; (312) 751-6634.

PHYSICIANS IN THE NEWS—**Maurice Cottle, M.D.**, Chicago, has been chosen to receive the Presidential Citation of the American Academy of Otolaryngology. The citation, which is the Academy's highest award, will be presented at the annual meeting in October. . . . **Abe L. Aaronson, M.D.**, Chicago, was recently honored at a meeting of the Physicians and Surgeons Division, Jewish United Fund. . . . **Robert R. J. Hilker, M.D.**, medical director for Illinois Bell Telephone in Chicago, recently received the Meritorious Service Award of the American Occupational Medicine Association, for his service to the organization as a member and as 1976-77 president.

The American Occupational Medicine Association also announced that **Fern E. Asma, M.D.**, assistant medical director for Illinois Bell Telephone in Chicago, has been elected to their new Board of Directors.

Chicago resident physician **William E. Golden, M.D.**, will share this year's Morris Fishbein Fellowship in Medical Journalism awarded by the AMA. Dr. Golden is former editor of the annual *Guide to Baylor College of Medicine*, and "*Pulse*," the newsletter of the AMA student section. (Dr. Golden was recently elected Vice Chairman and Delegate to ISMS by the ISMS Resident Physician Section).

H. Constance Bonbrest, M.D., Chicago, associate director of Health Services Programs for the Urban Health Program, University of Illinois Medical Center, has been appointed to a 2½ year term as a member of the National Professional Standards Review Council.

Ann Irish, M.D., director of medical education at Central DuPage Hospital in Winfield, has been appointed to a three-year term on the Review Committee of the Liaison Committee on Continuing Medical Education. The Review Committee analyzes reports from CME accreditation surveys and makes recommendations to the Liaison Committee for accreditation decisions.

Neil A. Kurtzman, M.D., Chicago, has been elected chairman of the Medical Advisory Board of the Kidney Foundation of Illinois. The Medical Advisory Board coordinates and approves all major medical and scientific activities of the Foundation, including continuing education, research and public information activities.

Jack Weinberg, M.D., Glencoe, has been named the first Distinguished Senior Scholar by the National Institute of Mental Health under an agreement between Rush Medical College and the NIMH Center for Studies of Mental Health and the Aging. He will study curricula and training methods currently in use by medical school and residency training programs to prepare professionals to work with the elderly.

The American College of Cardiology has named four additional Illinois physicians to the rank of Fellows of the College. These are **David J. Hale, M.D.**, **Sarah A. Johnson, M.D.**, and **Henry J. Sullivan, M.D.**, all of Maywood, and **Richard C. Smith, Jr., M.D., D.O.**, of Chicago. The new fellowships were announced by **Benjamin M. Kaplan, M.D.**, Chicago, newly elected member of the Board of Governors, representing the state of Illinois.

AN INVITATION—The 1979 Scientific Session of the Iowa Medical Society is scheduled for June 18-20 at Marriott's Tan-Tar-A Resort, Osage Beach, Missouri. IMS has invited interested ISMS members to attend the program, for which participants will be eligible to receive 11½ hours of Category 1 CME credit. If interested, please contact Ms. Tina Preftakes, Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265, or call (515) 223-1401.

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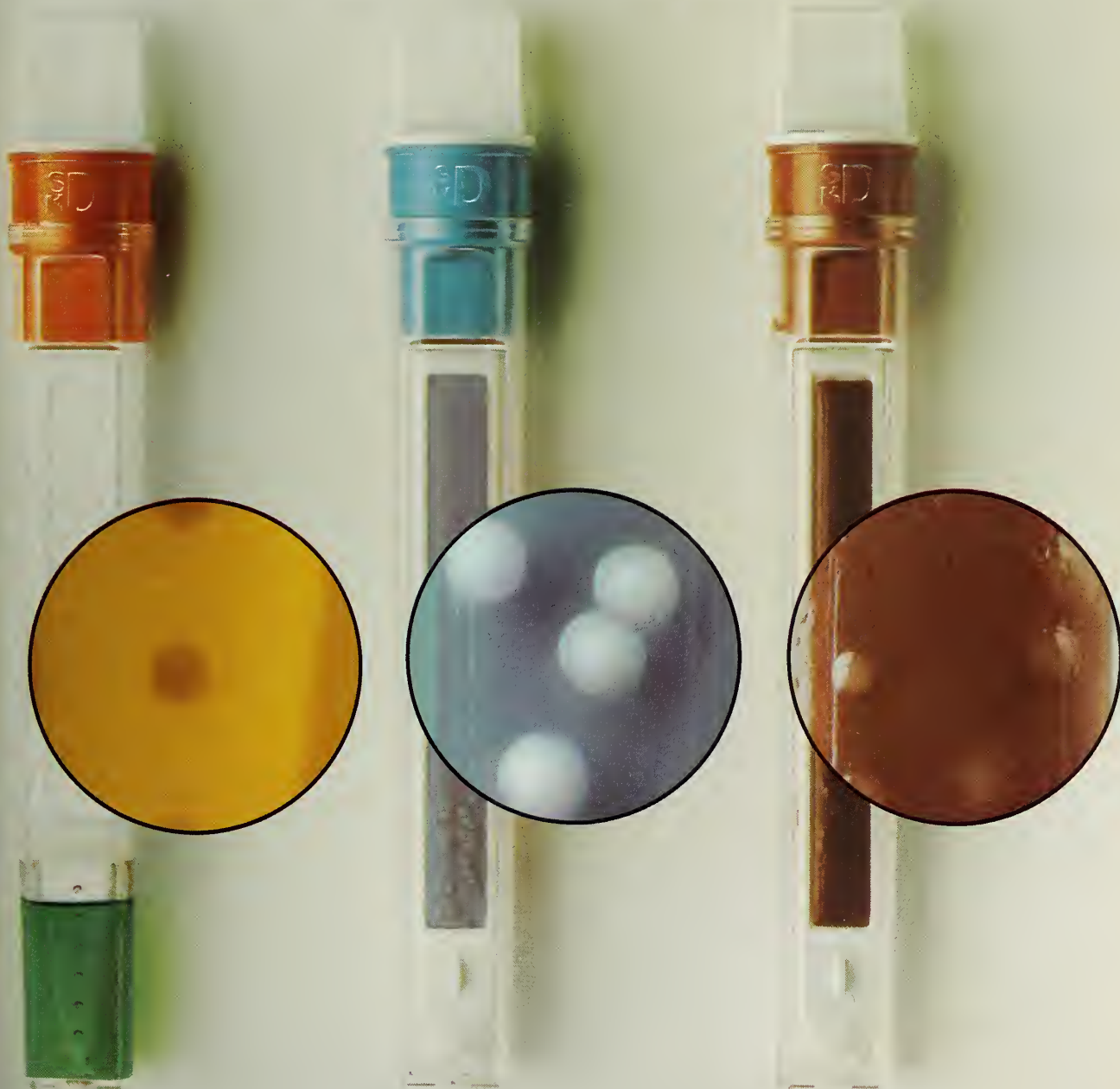
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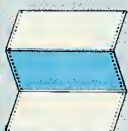
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EKG

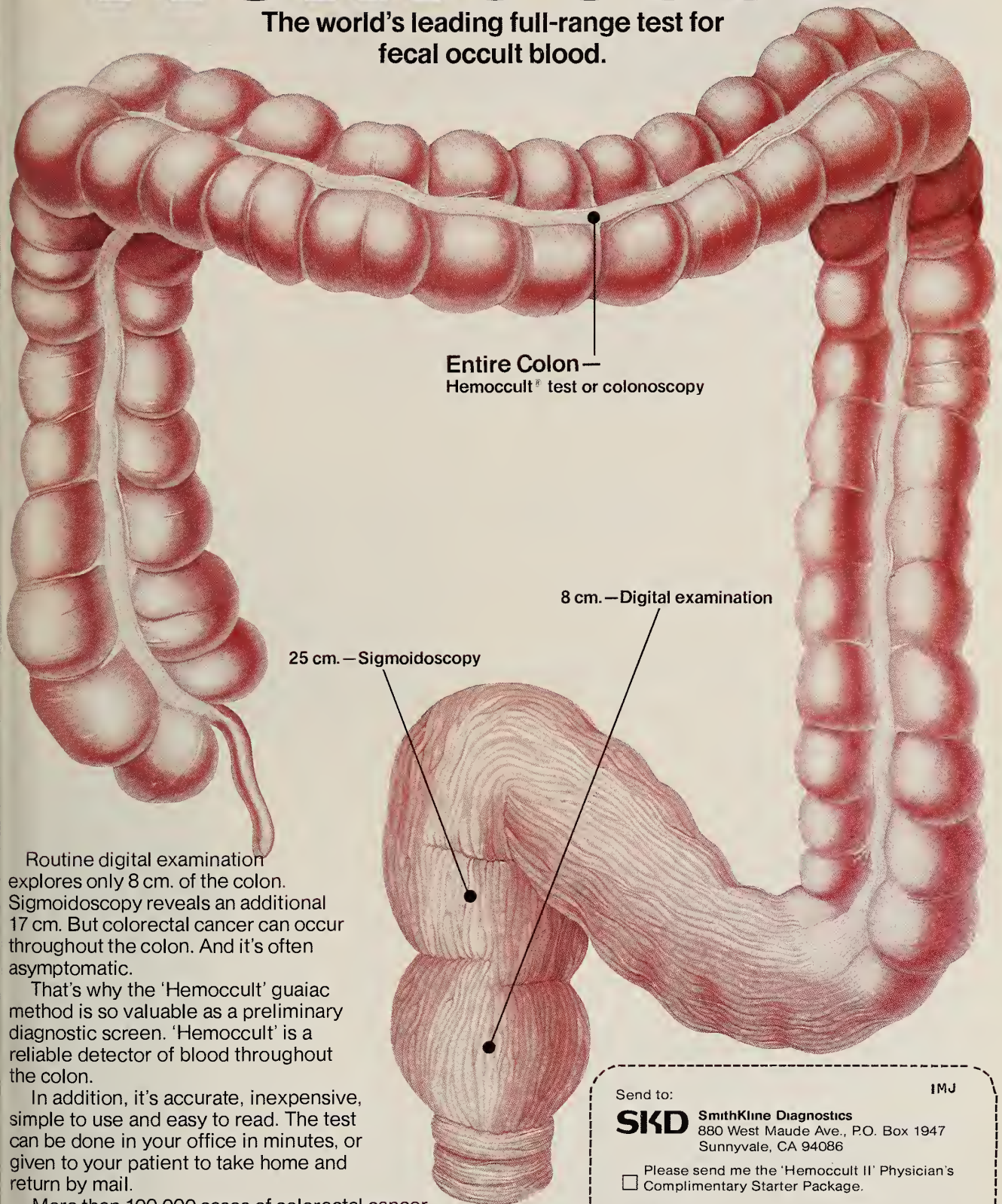
(Continued from page 358)

Answers: 1. E 2. D

The pertinent part of the ECG was shown on this six lead section. The last three beats of each line show the paroxysmal atrial tachycardia with irregular atrial cycles. This is best seen in the last three beats in lead AVF. The sinus P waves are 0.12 seconds wide and notched for a diagnosis of left atrial enlargement. The ST-T waves seen in leads II, III, and AVF and the relatively shortened Q-T interval at 0.28 seconds are compatible with Digoxin effect. In the first five beats of lead II, the R-R cycles are regular but the sinus P waves are not. This creates an appearance of changing PR intervals and probably represents a short run of AV dissociation. The PR intervals of beats 2, 3, 4 and 5 in lead AVF are normal. The last three P waves in lead II and the last four P waves of lead AVF are much taller than the sinus P waves, have irregular P-P cycles, and represent the paroxysmal atrial tachycardia. It is not unusual to see premature beats or short runs of AV dissociation following D.C. cardioversion but it usually occurs shortly after the shock. This arrhythmia was seen several hours later and suggested an excess of Digoxin. In the absence of atrial fibrillation, her requirement for Digoxin had decreased. The answer here is not that clear cut, however. Even though the mitral valve obstruction had been relieved and presumably the left atrial pressure is now normal, the left atrium is still enlarged. Since maintenance of sinus rhythm after conversion from atrial fibrillation is related to the pressure as well as the volume of the atria, Quinidine therapy for atrial stabilization could be required. In fact, Quinidine was added to this patient's therapeutic regimen later the next day. Irregular P-P cycles in atrial tachycardias are often associated with a return to atrial fibrillation, but thus far our patient has maintained sinus rhythm.

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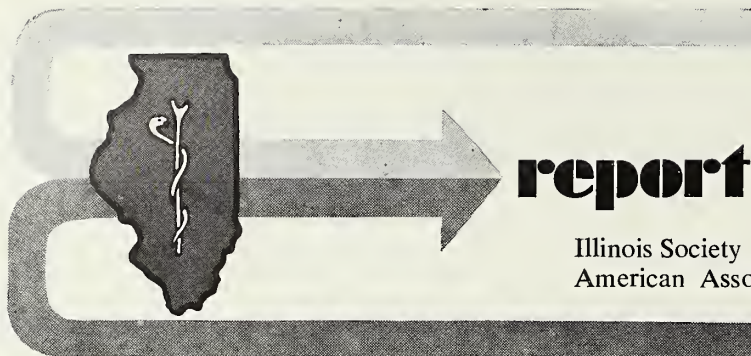
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Illinois Society
American Association of Medical Assistants

History of the American Association of Medical Assistants

The American Association of Medical Assistants (AAMA) is a national, non-profit organization dedicated to the professional advancement of medical assistants. Its educational services enable members to increase their effectiveness to the physicians and patients they serve and to advance professionally.

AAMA membership includes medical assistants, medical assisting educators and students. As of January, 1979, there were 19,000 AAMA members nationwide, in 560 local chapters in 46 states and the District of Columbia. Nearly 2,000 physicians serve as AAMA advisors at local, state and national levels.

1955—National organizational meeting in Kansas City, Kansas. There were 15 states represented (Illinois was one of the states). **1956**—Charter Meeting held in Milwaukee, Wisconsin, and AMA passed resolution commending the objectives of AAMA. **1957**—First Annual Meeting—The House of Delegates was accepted as the legislative body of the national association. **1958**—Tri-level membership was approved. **1959**—AAMA was incorporated in the State of Illinois as a not-for-profit educational organization. The national headquarters was opened in Chicago, Illinois. The Maxine Williams Scholarship Fund was established (named for the first national AAMA President).

1960—A Speaker and Vice Speaker of the House of Delegates were added to the roster of officers. **1961**—The Certifying Board was established through a resolution defining its structure, power and purposes. **1962**—Financial grants from several groups contributed to the educational and organizational growth of AAMA. **1963**—The first certification examinations were given. **1964**—A leadership training program was inaugurated to strengthen educational programming for medical assistants throughout the country. **1965**—The national headquarters space and staff was expanded and the position of Executive Director was created. **1966**—A special committee was appointed to develop curriculum

standards for the training of medical assistants, as a prelude to collaborating with AMA in the accreditation of educational programs on a post-secondary level. **1967**—The Research and Development Committee was created to foster long term planning for the association. **1968**—The AAMA endowment was established as a public foundation for educational, charitable, and scientific purposes. **1969**—The "Essentials of an Approved Educational Program for Medical Assistants" were approved by the AMA Council on Medical Education and the AMA House of Delegates.

1970—An educational task force, representing five specialty societies, plus AMA and AAMA began working on a means to incorporate specialty training into the two-year medical assisting curriculum. **1971**—A session for medical assisting instructors was included in the annual convention program. **1972**—AMA/AAMA filed a petition with the U.S. Office of Education seeking recognition as the official accrediting agency for medical assisting programs. **1973**—The first annual Professional Development Institute was held for medical assisting educators and medical assistants planning to become instructors. **1974**—The U.S. Office of Education recognized AMA/AAMA as an official accrediting agency for medical assisting programs in public and private institutions. **1975**—The first Guided Study Course in Anatomy, Terminology, and Physiology was offered. **1976**—AAMA's 20th Anniversary, which was filled with many reminiscences. A new category of membership "International" was instituted. AAMA members attended the annual convention of the Association of Medical Secretaries in London, England.

An update from 1976 to 1979 will be continued in a later issue. For information regarding AAMA—Illinois Society—contact:

Cissy A. Egly, CMA., President, 1413 S. Midland Court, Joliet, IL 60436; or Luella V. Mitchell, chairman, Public Relations Committee, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

For hemorrhoids and other anorectal conditions



External hemorrhoids



Internal hemorrhoids



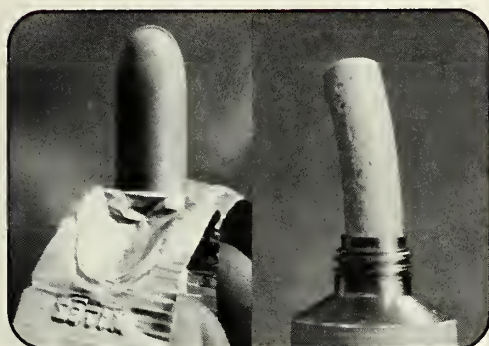
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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol-HC[®] Suppositories or Ointment.

Contraindications: Anusol-HC[®] Suppositories and Anusol-HC[®] Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

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Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

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and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

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How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label.

Store between 15°-30° C (59°-86° F).

Full information is available on request.

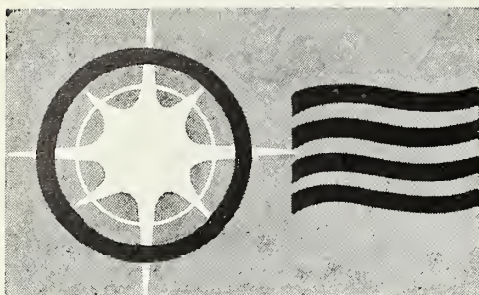


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membership forum

Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

Further Action Urged

I agree with every word written by our President on page 447 of the December, 1978, issue of the *Illinois Medical Journal*. It is therefore regrettable that Dr. Fox omitted to point out that the House of Delegates had already sanctioned the formation of a task force which has produced one little gem called "Government Controlled Medical Care—Hazardous to Your Health" and then appears to have gone into honorable retirement.

The function of the task force was to coordinate public speaking and writing. A rebuttal section was supposed to take instant action against any and all of the irritating barbs which are launched at us by the media. It was also supposed to keep the general public informed about such diverse items as HSA, PSRO, CME, Cost Containment, and second opinions.

If we really mean to be heard we must choose a vigorous and eloquent committee and put them to work at once to implement the intent behind the resurrection of this informational body.

Yours Sincerely,

James W. Sutherland, M.D.
Ch. M. (Hons) Glasgow
FRCS. Eng., FRCS. Ed.

Active Retirement Years

Gentlemen:

There are about 270 physicians belonging to the Sun City Physicians Club. I was elected president last June and nominated to serve another year at our last meeting. We hold a

monthly breakfast meeting except during the summer months and we hold three Ladies Day Parties.

You may also be interested in knowing what a retired physician does. After retiring from the Evanston-North Shore Health Department as its Public Health Director in '73, I took a position with the V.A. Research Hospital in Chicago for over a year until our home in Sun City was built. Then after moving to Arizona, took a similar position with the Phoenix V.A. Hosp. for almost a year. The following year I worked in three clinics operated by the Maricopa County Health Department. The next year I worked for the same department in several nursing homes on a part-time basis. The next year I split the summer with another Sun City physician and worked two months as the only physician in Grand Teton National Park at Jackson Lake Lodge. Started work last July as consultant to the Disability Certification Section of the State Dept. of Economic Security. We process claims under Title II—Social Security and Title XVI—Welfare. Am still there.

In my spare time I bowl, golf, attend Lions meetings and meetings of the Model Railroad Club where I was its secretary for two years.

Sincerely,

Allan Filek, M.D.

On Length of Stay

To the Editor:

A few years ago, when the cost of health care increased, the government sought an easy solution. Among the myriad of causes a few easily identifiable factors stood out. One of these was the excessive length of hospital stay. But no one was willing

to reduce the length of hospitalization until the government exerted pressure in form of a review mechanism. This called for a nationwide organization: part time and full time surveyors, supervisors, mindboggling forms, carbon copies and endless reports to various agencies. This was not without a price. It added several dollars to the daily bill of every hospitalized patient. In one way this effort was successful. The length of stay in our hospitals is getting shorter and I expect this trend to continue. This is good news. But while the length of hospital stay is declining, it is also a fact that the cost of hospital care continues to increase. If the length of hospital stay was a factor in health care cost, it must have been a minor one. Today it does not appear to be a factor of any importance.

We got the message. We have to reduce the length of stay. But it appears to me that we spend a lot of time and money on the wrong cause of hospital cost. The length of stay can be monitored by a part time clerk. Any deviation from a reasonable standard can be easily spot-checked. The inevitable conclusion appears to me: THE CURRENT REDUNDANT AND EXPENSIVE MECHANISM MONITORING THE LENGTH OF STAY IN HOSPITALS SHOULD BE DISMANTELED. IT WOULD RESULT IN IMMEDIATE REDUCTION OF HOSPITAL COST.

Secretary Califano and the HEW appear to become experts on cost effectiveness. This would be a good place to start. The trouble with bureaucracies is that after a while, when the original intent is forgotten, their only aim is to preserve and perpetuate themselves.

James Scott, M.D.
Streator



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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BUNKER HILL: Rural community, trade area 3000. Doctor retiring. Living quarters and office space available. Excellent schools and churches. Fifty miles, north-east of St. Louis, Mo. Financial assistance available if necessary. Contact: Sally Bruckert, RR #1 Box 488, Bunker Hill 62014, 618-585-3192. (7)

DANVILLE: More than would be expected in a city of 43,000. Area population of 190,000 served by two medium sized community hospitals. An industrial medicine specialist or a neurosurgeon would find above average opportunities for professional growth. Area offers all the advantages of a smaller city life plus easy access to major urban areas. CONTACT: Richard V. Liven-good, President, Lakeview Medical Center, 812 North Logan Avenue, Danville, 61832. (9)

ELDORADO: Busy six-doctor practice looking for G.P./F.P., General Surgeon and Ophthalmologist. \$36,000 guaranteed first year. Located in town of 5000 in scenic southern Illinois. Call Dr. Elliott O. Partridge or Dr. Denton B. Ferrell, (618) 273-3361. (7)

FAIRFIELD: Need one family practitioner and one Gyn-OB man for an established two men (F.P. & Gen. Surgeon) practice in a 6500 population community. Drawing area 20,000. Excellent salary and fringe benefits. Very well equipped hospital. Excellent local schools and junior college. University 75 miles. Good recreational facilities and churches. Contact S. W. Konarski, M.D., 101 East Center Street, Fairfield, 618-842-2187. (7)

ILLINOIS: The Illinois Dept. of Corrections has immediate openings statewide for Family Practice or General Practice Physicians interested in ambulatory care. For additional information and salary schedule contact: Cecil Patmon, 160 N. LaSalle, Chicago, 60601, 312/793-3216. (6)

JACKSONVILLE: Opportunities for family practice emergency room, dermatology, OB/GYN, orthopedic surgery. Progressive 250 bed hospital, 40-member medical staff. Prosperous community with primary service area of 60,000, two colleges, excellent schools, 35 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Area Hospital, Jacksonville, 62650 (217) 245-9541. (6)

MATTOON: Family practitioner or internist for rewarding primary care practice. Fully equipped office available—New 210-bed hospital (open staff)—Financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient draw of 75,000. Contact: A. P. Rauwolf, M.D., 1120 Wabash, Mattoon, 61938, (217) 234-6253. (10)

MINIER: General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity in solo or group practice. Contact: Carol Nafziger, Minier 61759, (309) 392-2345 or 392-2120. (6)

MUNSTER, IN.: Family, ENT, Ortho.; for large mid-west multi-specialty group. Competitive first year salary with opportunity for early partnership. No investment. Most liberal vacation and P-G allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop own practice. Send C-V to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321 (219) 836-5800. (6)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensa-

tion negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

OQUAWKA: Population of County—8,000. Opening in new medical clinic. Ninety-five miles from Peoria. Complete office facilities. Near colleges. All recreational facilities nearby. CONTACT: HENDERSON COUNTY HEALTH DEPARTMENT, P.O. Box 186, Oquawka, 61469, (309) 867-2202. (10)

PEORIA: Orthopedic Surgeon needed in multi-specialty clinic of 12 physicians. Excellent opportunity for the right person. Located in community of 250,000, three hospitals, school of medicine. Guaranteed first year salary plus complete fringe package. Contact: Dr. R. Martin, The Medical and Surgical Clinic, S.C. 100 N.E. Randolph, Peoria, 61606. (6)

PIKE COUNTY: Population 19,000. Two general practitioners, one general surgeon, office space available beside 82 bed, JCAH, full service hospital. Financial assistance available. Ten physicians at present. Great hunting. Gary Deer, Administrator, Illini Community Hospital, 640 West Washington, Pittsfield, AC(217) 285-2113. (6)

PITTSFIELD: Family Practitioner/General Practitioner/General Surgeon to join established practice or solo. Minimum guarantee, office space available free. 82 bed JCAH full service hospital. Great bird/duck hunting. Contact Gary Deer, Illini Community Hospital, 640 W. Washington Street, Pittsfield 62363; (217-285-2113.) (7)

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STERLING/ROCK FALLS: Primary Care physicians needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

SYCAMORE: Associate Desired—for July, 1980. Family practitioner to join two family physicians and internist in a newly formed group. Situated 112 kms west of Chicago in a semi-rural area. Family practice oriented hospital, with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D. (Director), 954 West State Street, Sycamore, 60178, (815) 895-9144. (9)

VALMEYER: Population 1000 with patient population of 3-4000. Scenic town on small lake. 25 miles from Belleville or Red Bud, 35 miles from St. Louis, Mo. Only physician is about to retire. Fully equipped 4 room office building for rent. Contact: H. A. Reichel, M.D., 206 W. Main, Valmeyer, IL 62295. (618) 935-2216. (6)

VANDALIA: County Hospital, serving population 25,000. Seven physicians at present. Sixty miles east of St. Louis on Interstate Highway I-70. Office space available on hospital campus. Financial assistance and deferred compensation agreements available. Contact John R. Leckrone, Administrator, Fayette County Hospital, 7th & Taylor, Vandalia 62471. (618) 283-1231. (7)

Illinois Medical Journal

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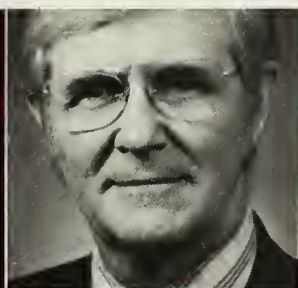
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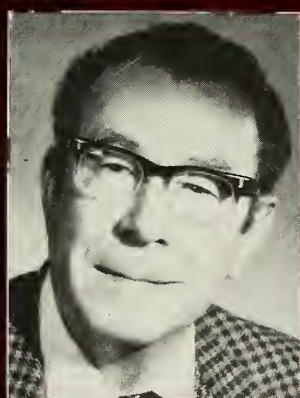
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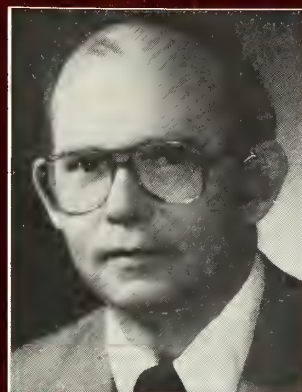
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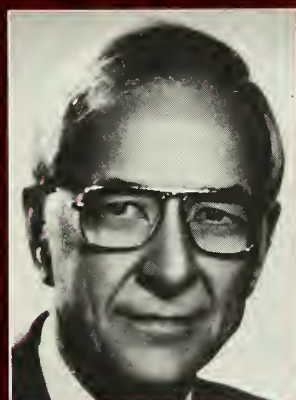
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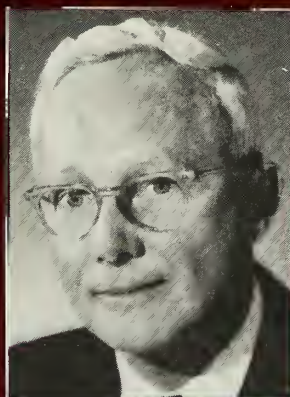
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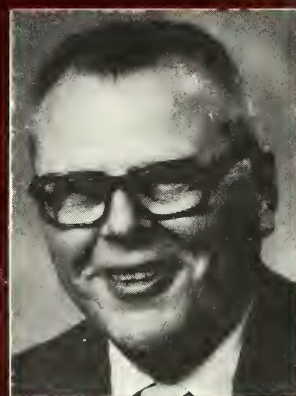
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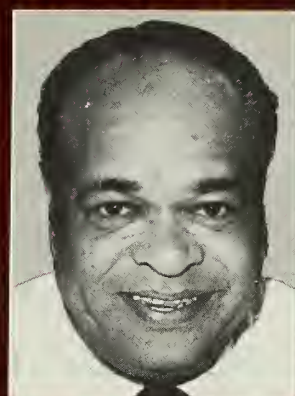
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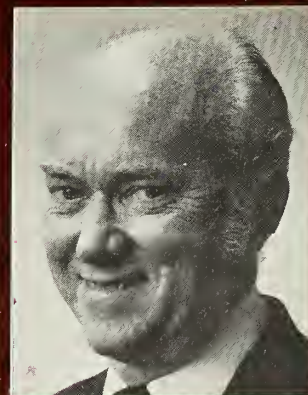
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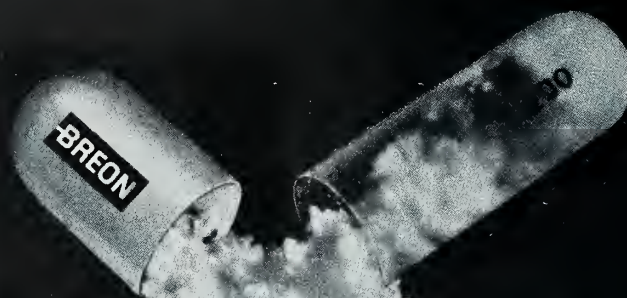


Fred Z. White
First Vice President

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Convention Summary ... 31

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CONTRAINDICATIONS: Hypersensitivity to any of its components.

WARNINGS: Theophylline should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

arrhythmias may be worsened by theophylline.

Usage in Pregnancy: Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

Theophylline should not be administered concurrently with other xanthines.

Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

ADVERSE REACTIONS: Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea. **CNS:** headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. **Cardiovascular:** palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. **Respiratory:** tachypnea. **Renal:** diuresis, albuminuria. **Other:** hyperglycemia, inappropriate ADH

secretion.

Drug Interactions: Toxic synergism with ephedrine and other sympathomimetic bronchodilators may occur.

OVERDOSAGE Treatment:

- If potential oral overdose is established and seizure has not occurred: 1) Induce vomiting. 2) Administer a cathartic. 3) Administer activated charcoal.
- If patient is having a seizure: 1) Establish airway. 2) Administer O₂. 3) Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg. 4) Monitor vital signs, maintain blood pressure and provide adequate hydration.
- Post-seizure coma: 1) Maintain airway and oxygenation. 2) If a result of oral medication, follow above recommendations to prevent absorption of drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube. 3) Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as to not warrant consideration of dialysis.

HOW SUPPLIED:

Bronkodyl 100 mg,
brown and white capsules in 100's
Bronkodyl 200 mg,
green and white capsules in 100's

Code 183

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Illinois Medical Journal

(USPS 258-160)

JULY, 1979

Vol. 156, No. 1

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A reminder

ZYLOPRIM[®]

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

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Abstracts of Board Actions

May 5-9, 1979

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Fee Adjudication

The ISMS Board of Trustees made the following recommendation concerning fee adjudication activities:

Component societies should give careful consideration to their policies and practices regarding fee adjudication and make their own decision based on local need. In the event the decision is to continue to review disputes involving physicians' fees, opinions rendered in these matters should be advisory only.

The ISMS Peer Review Appeals Committee will: (1) Refuse to consider cases requiring adjudication of fees; but (2) Continue to accept appeals of cases involving other peer review matters (necessity and appropriateness of care) if the appeals are filed in accordance with the Bylaws by physicians or patients.

The Peer Review Appeals Committee will publish a handbook—governing the conduct of peer review activities—to guide component medical societies.

Blue Cross/Blue Shield Medical Necessity Program

To clarify action taken at its last meeting concerning peer review under the Blue Cross/Blue Shield (BC/BS) Medical Necessity Program, the Board adopted the following position statement:

ISMS recognizes the need for third-party payors to determine whether or not a service was: (1) Performed according to accepted medical practice in the community; (2) Conducted in the appropriate setting; and (3) Necessitated by the patient's condition.

In the absence of other medical organization peer review mechanisms contracted to evaluate medical necessity, we believe the Utilization Review (UR) committee of the hospital where the service was performed is best suited to determine the need for the service, the appropriateness of the setting and the quality of the procedure.

ISMS, the Health Insurance Association of America, Illinois Hospital Association and BC/BS have taken positions supporting the "focused review" technique of utilization review and the responsibility of third-party payors to pay their share of the costs of this activity.

Therefore, the recent ISMS Board of Trustees' decision to encourage BC/BS to use hospital UR committees as a mechanism for services deemed "unnecessary" by BC/BS merely is an extension of previous ISMS policy. In practice, whenever a case is submitted for reimbursement to BC/BS—if it is to be questioned for its "necessity"—BC/BS should request an opinion on the case from the hospital utilization review committee of the facility where the services took place. Should BC/BS not have contacted the UR committee prior to making its decision, the physician should request BC/BS to seek such an opinion.

Legislation

ISMS will support legislation to transfer administration of a state-funded program for crippled and disabled children from the University of Illinois to the Illinois Department of Vocational Rehabilitation. The transfer will allow expansion of the program—now limited to children from

(Continued on page 48)

socult®

the inexpensive, in-office culture tests for *Trichomonas vaginalis*, *Candida* (Monilia), *N. gonorrhoeae*

as simple as swabbing a specimen on the culture media, inserting the color-coded tube into a slot of an office incubator and reading results against an identification chart 24 to 48 hours later.

All three tests contain highly selective media that give you the right results, right in your office. And there are also two combination tests that let you check for *N. gonorrhoeae* and *Candida* or *T. vaginalis* and *Candida* simultaneously.

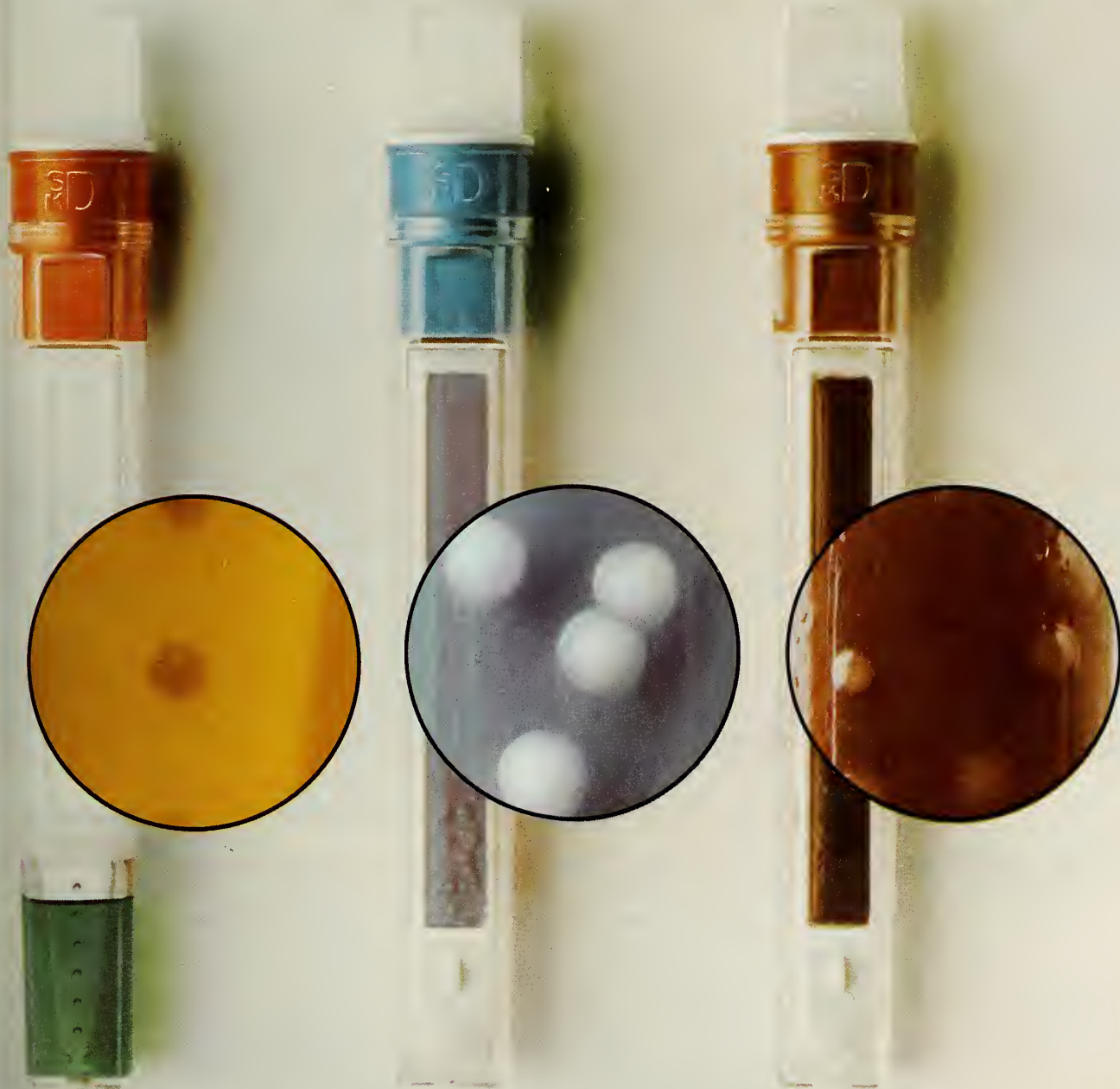
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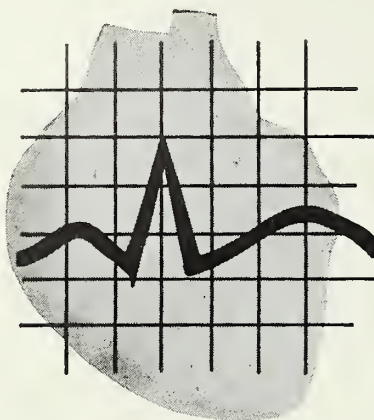
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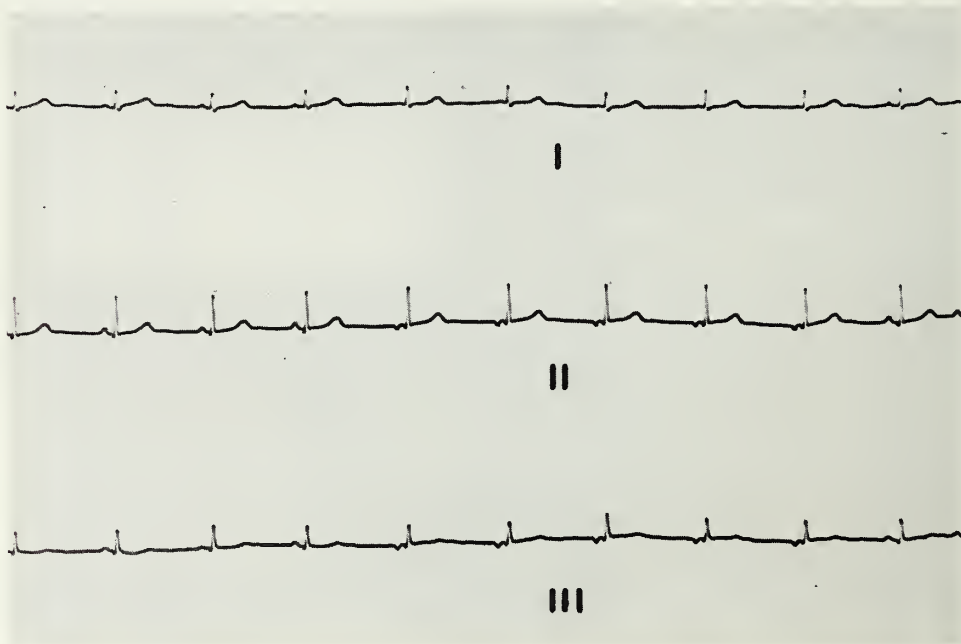
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
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JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

The patient is a forty-three-year-old woman who presented for evaluation of a headache which had been worsening for a month. The headache occurred at night and was present when the patient awakened the next morning. The headache was usually intensified by exertion, coughing, sneezing, or bending over. Her cardiac examination was normal except for a changing heart rate. A twelve lead ECG was normal and this lead I, II, III rhythm strip was taken.



Questions:

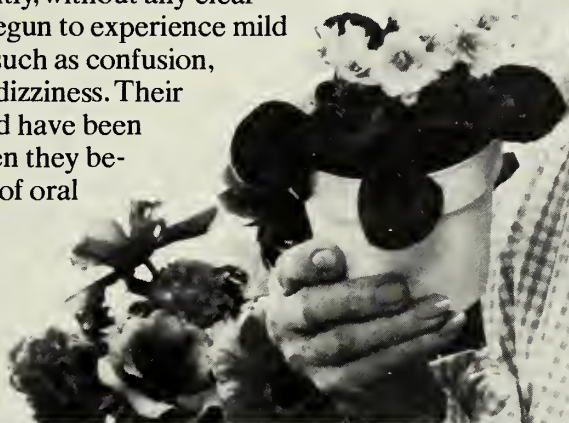
1. The ECG I, II, III rhythm strip shows:
 - A. Paroxysmal atrial tachycardia.
 - B. Intermittent coronary sinus rhythm.
 - C. Slowing of the sinus rate with the escape of a junctional pacemaker.
 - D. Cycle dependent bundle branch block.
 - E. Appearance of slow atrial flutter.
2. Treatment for this arrhythmia would be:
 - A. A permanent or temporary demand pacemaker.
 - B. Intravenous lidocaine: 100 mg. bolus followed by an intravenous infusion.
 - C. Oral procainamide or quinidine.
 - D. Digitalis
 - E. None of the above.

(Continued on page 78)

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

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Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

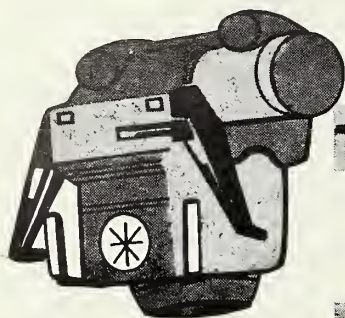
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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Richard E. Marsan, M.D., an assistant professor in the Loyola University Medical Center Department of Radiology.

This 51-year-old female had an eight month history of intermittent crampy abdominal pains exacerbated by eating. She experienced a moderate weight loss during this period. Past medical history included a cholecystectomy five years prior to admission. Physical examination, laboratory tests, chest X-ray, UGI and barium enema were normal. The small intestinal examination demonstrated an abnormality in the ileum.



Figure 1

What's your diagnosis?

1. Amyloid
2. Whipple's disease
3. Carcinoid
4. Giardiasis

(Continued on page 70)

GUEST EDITORIAL—

Task Force Achieves Key Mental Health Amendments

BY DAVID S. FOX, MD, CHAIRMAN
TASK FORCE ON THE MENTAL HEALTH CODE

The General Assembly's passage of amendments to the state's new Mental Health Code is evidence of the influence physicians can wield when their approach is unified rather than fragmented. By offering a united front to the legislature, we were able to achieve significant changes in a law that had been attacked by segments of the psychiatric community as detrimental to quality mental health care.

The amendments resulted from diligent efforts by the ISMS-sponsored Task Force on the Mental Health Code which brought together divergent viewpoints from ISMS, the Illinois Psychiatric Society, Illinois Nurses Association and Department of Mental Health and Developmental Disabilities.

The Task Force was created immediately before implementation of the new Code when psychiatrists expressed concern that the legalistic nature of the Code would interfere with the clinical needs of patients. Its first action was to retain an independent legal counsel with considerable expertise in mental health law to analyze the Code and identify provisions needing reform. The Task Force then embarked upon a two-pronged effort to develop legislative remedies and a series of guidelines to assist physicians and hospitals in implementing the law.

When developing its legislative strategy, the Task Force decided to seek important amendments which could be obtained without entering into philosophical battles over patient rights vs. treatment needs. Revisions not of immediate importance and subject to intense opposition will have to wait until future legislative sessions.

The initial amendments recently approved by the General Assembly address several key problem areas identified by the Task Force, including use of restraints and seclusion, explanation of patient rights upon admission and notification of relatives when rights are restricted. We are indebted to Sen. Richard M. Daley (D-Chicago) and Rep. Elroy Sandquist (R-Chicago) for their sponsorship of the proposals, and hope that Gov. Thompson recognizes their importance and signs them into law.

Meanwhile, the Task Force is continuing its work on suggested guidelines to assist physicians and hospitals in complying with the Code. An initial set of guidelines has been dispatched to all ISMS members and hospital chief executive officers because it is the Task Force's opinion that the new Mental Health Code governs treatment of any patient with a primary diagnosis that is psychiatric in nature—*whether hospitalized on a psychiatric unit or elsewhere*. An examination of the Code and analysis of certain sections are offered in a special article on page 21 of this issue.

The guidelines are intended to outline major provisions of the law, answer some commonly-asked questions and offer suggestions for coping with difficult sections of the Code. We will be issuing additional communications as more data become available or further revisions are made in the law. ◀



new pharmaceutical specialties

BY PAUL DEHAEN

BY PAUL DEHAEN, Information Systems
A Division of Micromedex, Inc.

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Drugs—Drugs not previously known, including news salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

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Supplied as: Powder for oral suspension
250 mg/5 ml: 80, 150 ml
Indication: For penicillin therapy
Dosage: Determined according to sensitivity of microorganisms

Prednisolone Acetate (DI-PRED—Central Pharmacal) Rx

Therapeutic Class: Corticoids
Supplied as: Vials; 20 mg/ml, 10 ml
Indication: Corticosteroid therapy
Dosage: See package insert

Rh₀ (D) Immune Globulin (Human) (MICRHOGAM—Ortho) Rx

Therapeutic Class: Biologicals
Supplied as: Vials
Indication: For prevention of maternal Rh immunization following abortion or miscarriage
Dosage: Individualized

NEW DOSAGE FORMS

ANTROCOL (Poythress) Rx

Therapeutic Class: Antispasmodic
Composition: Elixir; each ml contains
Atropine Sulfate 0.039 mg
Phenobarbital 3 mg
Alcohol 20% v/v
(Sugar Free)

Indications: For symptomatic relief of colic, pylorospasm and other functional gastrointestinal disturbances
Dosage: 0.5 ml/15 pounds body weight

Cephadrine (VELOSEF—Squibb) Rx

Therapeutic Class: Antibiotics—B & M Spectrum
Supplied as: IV infusion bottle containing:
Cephadrine 2.0 g
(Sodium-free)
Indications: For use as an antibiotic for susceptible micro-organisms
Dosage: Individualized according to sensitivity and severity

ENTUSS EXPECTORANT (Hauck) Rx

Therapeutic Class: Cough Preparation
Composition: Oral tablet
Hydrocodone bitartrate 5 mg
Guaifenesin 300 mg
Indications: For the symptomatic relief of dry, non-productive cough
Dosage: See package insert

IPSATOL P (Key) ®

Therapeutic Class: Cough Preparation
Composition: Oral tolu balsam syrup, each 5 ml containing:
Ipecac alkaloids 0.24 mg
Ammonium chloride 22 mg
Phenylpropanolamine HCl 12.5 mg
Indications: For the symptomatic relief of cough and nasal congestion
Dosage: See package labeling

NEOTHYLLINE-GG (Lemmon) Rx

Therapeutic Class: Bronchodilator
Composition: Each tablet contains:
Dyphylline 200 mg
Guaifenesin 200 mg
Each 30 ml of elixir contains:
Dyphylline 200 mg
Guaifenesin 200 mg
Alcohol 20%
Indications: For treatment of acute and chronic bronchitis, bronchial asthma, emphysema and related conditions
Dosage: Individualized

ParaAminobenzoic Acid (PRESUN CREAMY LOTION—Westwood) ®

Therapeutic Class: Emmolient & Protective
Supplied as: Topical Lotion
Indications: For use as a sunscreen
Dosage: See package labeling

PHENAPHEN-650 WITH CODEINE (Robbins) Rx

Therapeutic Class: Analgesics—Narcotics
Composition: Oral tablet
Acetaminophen 650 mg
Codeine 30 mg
Indications: For the relief of mild to moderate pain
Dosage: Individualized according to severity of symptoms

Povidone-Iodine (BETADINE VISCOUS FORMULA—Purdue-Frederick) Rx

Therapeutic Class: Antibacterials—General
Supplied as: Antiseptic Gauze Pads
Topical
Indications: For use as a topical microbicidal dressing

Theophylline (THEOLAIR LIQUID—Riker) Rx

Therapeutic Class: Bronchodilator
Supplied as: Each 15 ml contains:
Theophylline 80 mg
(Nonalcoholic)
Indication: For relief of asthma
Dosage: See package insert

COMBINATION PRODUCTS

HEATROL (Cross) ®

Composition: Each tablet contains:
Sodium Chloride 635 mg
Potassium Chloride 40 mg
Calcium Phosphate Tribasic 31.5 mg
Magnesium Carbonate 9 mg
Therapeutic Class: Electrolyte Replacement
Indication: For replacement of electrolytes lost due to perspiration
Dosage: Two tablets/dose; maximum, 10 daily

MIZYME (Misemer) Rx

Composition: Each tablet contains:
Pepsin 150 mg
Pancreatic Enzyme 100 mg
Ox Bile Extract 100 mg
Cellulase 10 mg
Therapeutic Class: Enzymes—Digestive
Indication: Digestive aid and/or enzyme supplement
Dosage: One or two tablets with each meal

MOTOFEN/MOTOFEN HALF STRENGTH (McNeil) Rx

Composition: Each tablet contains:
Difenoxin 1 mg, 0.5 mg
Atropine Sulfate 0.025 mg, 0.025 mg
Indication: Antidiarrheals
Therapeutic Class: For treatment of diarrhea
Dosage: See package insert

VICODEN (Knoll)

Rx

Composition: Each tablet contains:
Hydrocodone Bitartrate 5 mg
Acetaminophen 500 mg
Therapeutic Class: Analgesic—Narcotics
Indication: For relief of moderate to moderately severe pain
Dosage: One tablet every 6 hours as needed for pain

DUPLICATE SINGLE PRODUCTS

Acetaminophen (ACEPHEN—G & W Labs)

Therapeutic Class: Analgesics—Nonnarcotics
Supplied as: Suppository; 650 mg, 120 mg
Indication: For temporary relief of fever, minor aches and pains
Dosage: Individualized according to age and severity of symptoms

Chlordiazepoxide HCl (ZETRAN—Hauck) Rx

Therapeutic Class: Ataraxic
Supplied as: Capsule; 10 mg
Indication: For relief of anxiety and tension
Dosage: Varies with severity and response of patient

Coccidioidin (SPHERULIN—Berkeley Biologicals) Rx

Therapeutic Class: Diagnostics—Other
Supplied as: Vials; 0.5 ml 1:10 equiv
0.5 ml 1:100 equiv
Indication: For coccidioidomycosis diagnosis
Dosage: 0.1 ml intradermally

Metoprolol Tartrate (LOPRESSOR—Geigy) Rx

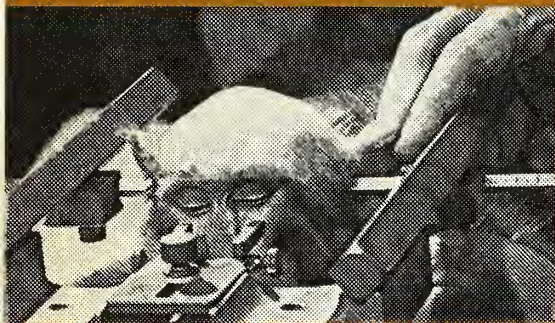
Therapeutic Class: Hypotensive
FDA Approval: August, 1978
Chemistry: 1-(isopropylamino)-3-(p-(2-methoxyethyl)phenoxy)-2-propanol
Supplied: Tablets, 50 and 100 mg
Indications: Hypertension
Contraindications: Sinus bradycardia, heart block greater than first degree, cardiogenic shock, and overt cardiac failure
Dosage: Initially, 50 mg twice daily, whether used alone or added to a diuretic. May be increased at weekly (or longer) intervals until optimum blood pressure is achieved.

Timolol Maleate (TIMOPTIC—Merck, Sharp & Dohme) Rx

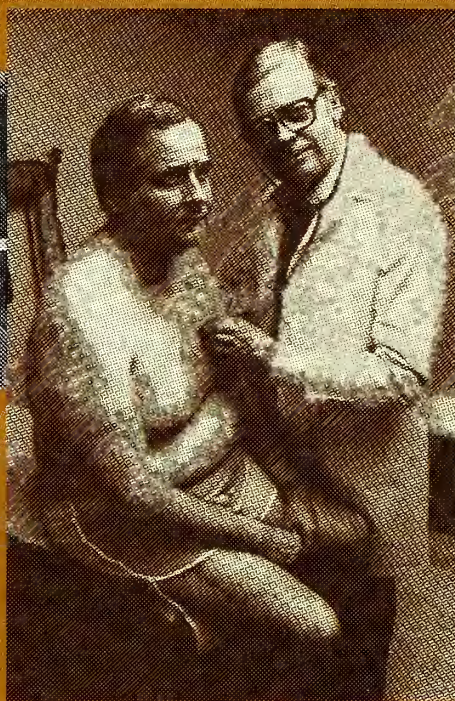
Therapeutic Class: Eye Preparations
FDA Approval: August, 1978
Chemistry: (-)-1-(tert-butylamino)-3-((4-morpholino-1,2,5-thiadiazol-3-yl) oxy)-2-propanol maleate
Supplied: Ophthalmic Solution
2.5 mg/ml (0.25%)
5.0 mg/ml (0.5%)
Indications: Reduction of elevated intraocular pressure
Contraindications: Hypersensitivity to any component of this product
Dosage: Starting dose is one drop bid of the 0.25% solution

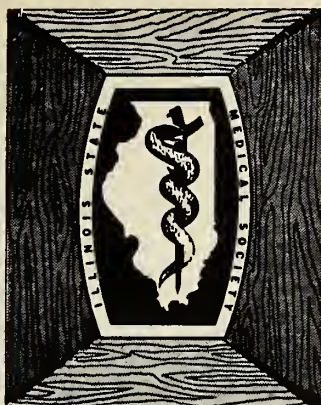
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I M J

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An Overview for Illinois Physicians

The New Mental Health Code

BY CHARLES A. LEVIE, M.D., JAMES L. CAVANAUGH, M.D., AND
BARBARA WEINER, J.D.

This paper highlights several parts of the new Illinois Medical Health Code. Restrictions on the use of restraints and seclusions are spelled out. Mechanisms for hospitalizing emergency patients on an involuntary basis should be useful to all Illinois physicians. It is important to know the law, in order not to break it. The practice of automatically hospitalizing and treating sick patients (e.g.—hallucinating schizophrenics) just because they are sick is illegal. The patient (always called "recipient" in the law) must also be dangerous to himself or others, and the patient's legal rights must be carefully protected every step of the way.

In August, 1978, Governor James Thompson signed into law a massively revised mental health code for the State of Illinois, Law number SB 250, replacing the 1967 code. The Governor's Commission for Revision of the Mental Health Code was appointed by former Governor Dan Walker in 1974. Upon implementation on January 1, 1979, their work was completed. The Commission, with three executive directors, and a final budget in excess of a half million dollars, consisted of lawyers, judges, psychiatrists, other

mental health professionals, and consumers. The potential impact of the code on the providers and consumers of mental health care services in the state has both been lauded¹ and lamented.^{2,3}

The purpose of this paper is to present the important points of SB 250. Whether many laudable goals of the new mental health code will be reached is still a matter of speculation. Sufficient time must be allowed to assess its impact on medical practice. The Illinois State Medical Society and Illinois Psychiatric Society have coalesced a select group of physicians, as well as representatives of the Illinois Nurses Association and IDMHDD, to monitor implementation of the new code.

More specific concern has been expressed⁴ related to the commitment procedures and clinical treatment revisions contained in SB 250. The new code has implications for all physicians in Illinois. This paper will briefly review some of the pertinent issues raised by these and other clinically relevant sections. Though psychiatrists in hospitals with psychiatric inpatient units are the major group of physicians impacted upon by the new code, the changes in the new law have implications for all medical practitioners.

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Definitions

(Chapter I)

1. *Clinical Psychologist*—Ph.D. plus 2 years supervised training in health service program, or M.A. and 6 years experience with 2 in a health service program. (Sec. 1-103)

2. *Developmental disability*—means disability attributable to mental retardation, cerebral palsy, epilepsy or autism. Must originate before person is 18. (Sec. 1-107)

3. *Mental health facility*—is defined to include licensed private hospitals.

4. *Person subject to involuntary admission* (a) a mentally ill person who, because of his illness, is reasonably expected to inflict serious physical harm upon himself or another in the

near future; or (b) a mentally ill person—who can't provide for his basic needs to guard himself from harm. (Sec. 1-119)

5. *Qualified examiner*—(1) MS Social Worker or (2) RN with MS in psychiatric nursing. Both must have 3 years of clinical training and experience in evaluation and treatment of mental illness. (Sec. 1-122)

6. *Seclusion*—Leaving patient in a room from which he has no means of leaving. It is not considered seclusion when the person is in a behavior modification program and must be restricted pursuant to an individual treatment plan. (Sec. 1-126)

Patients' rights

(Chapter II)

1. Continuing to be considered *competent*. Incompetency must be determined by a court in a separate judicial proceeding from that in which the patient is involuntarily hospitalized. (Sec. 2-101)

2. The right to receive services in "the least restrictive environment," as formulated in an individualized treatment plan. (Sec. 2-102)

3. The right to receive and send mail, have telephones "reasonably accessible," and to have space for visits available. Phone calls of the patient can be restricted to protect the recipient from harassment or intimidation. (Sec. 2-103)

4. The right to keep personal property. This can be restricted to keep the patient from harming himself or others. With notice to patients, the hospital can also generally restrict certain personal items for all inpatients (e.g., TV, radios, razors, bottles, knives, etc.) (Sec. 2-104)

5. The "right to refuse treatment," including medication, "unless such services are necessary to prevent the recipient from causing serious harm to himself or others." (Sec. 2-107) For example, an acutely psychotic and agitated patient may be given medications, but he would still have the right to refuse other aspects of hospital treatment, such as Occupational or Recreational Therapy.

6. The use of *restraints* is rigidly restricted (Sec. 2-108). (a) Basically, it "may be used only

as a therapeutic measure to prevent a recipient from causing physical harm to himself or others." The patient must first be seen by a physician, and an order for PRN restraint lasts a maximum of 12 hours. (b) In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only when a physician is not immediately available. In such event, a written order of a physician shall be obtained as quickly as possible, but no later than eight hours after the initial employment of such emergency restraint. Whoever originally orders restraint in such emergency situations shall document its necessity and place that documentation in the patient's record.

7. *Seclusion* (Sec. 2-109) is similarly restricted, and "employed only upon the written order of a physician . . . after personally observing and examining the recipient." (a) The order shall state the events leading up to the need for seclusion and the reasons why which such seclusion is needed. The order is valid for a maximum of eight hours. If further seclusion is required, a new order must be issued by a physician. (b) The physician who orders seclusion shall inform the facility director in writing of the use of seclusion as soon as practicable. (c) Seclusion may be employed during all or part of one eight hour period, beginning with the initial application of

the seclusion. The facility director shall review all seclusion orders daily and, once seclusion has been employed during one eight hour period, further seclusion during the next two following calendar days requires written authorization of the facility director. (d) The physician who ordered the seclusion shall assign a qualified person to observe the secluded recipient at least every 15 minutes. Such qualified person shall maintain a record of such observations. (e) Safety precautions shall be followed to prevent injuries to the recipient in the seclusion room. Seclusion rooms shall be adequately lighted, heated, and furnished. If a door is locked, someone with a key shall be in constant attendance nearby.

8. Electroconvulsive therapy (ECT) is not allowed without the patient's "written and informed consent." (Sec. 2-110).

9. Special provisions are made for medical emergencies: "Essential medical or dental procedures may be performed without consent" if a physician or licensed dentist examines the patient and determines that he is not capable of giving informed consent. Here the law seems to provide some protection to professionals acting in good faith stating, "No physician nor licensed dentist shall be liable for a non-negligent good-faith determination that a medical or dental emergency exists." (Sec. 2-111)

10. Every patient age 12 or older *and* the parent or guardian "shall be informed orally and in writing of the rights guaranteed" (by the law.) (Sec. 2-200) "A summary of these rights shall also be posted conspicuously in public areas of every facility that provides service." For example, this would include the bulletin boards of psychiatric wards which accept involuntary patients. (See Appendix for suggested sample form.)

11. The code requires that the facility director shall adopt in writing such policies and procedures necessary to ensure the patient's rights. (Sec. 2-202)

12. Patients have the right to legal representation. This will involve the newly created Guardianship and Mental Health Advocacy Commission, who will probably utilize to some degree the services of Public Defenders and/or other attorneys employed by the Mental Health Legal Advocacy Service. In our opinion, mutual respect and cooperation among involved physicians and attorneys is essential to implementation of the code. The code mandates that the "State's Attorneys of the several counties shall represent the people of the state of Illinois in court proceedings . . ." (Sec. 3-101)

13. A patient must be provided with the address and phone number of the Guardianship and Mental Health Advocacy Commission whenever he "is admitted, *is denied admission*, or objects to admission, and whenever a patient is notified that he is to be transferred or discharged or that his legal status is to be changed." (Emphasis added.) (Sec. 3-206)

14. An important point in the code is the examiner's obligation to "inform the person being examined in a simple comprehensible manner of the purpose of the examination, *that he does not have to talk to the examiner*, and that any statements he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission. If the person being examined has not been so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission." (Sec. 3-208) This seems to be a Miranda-type warning, which physicians are completely unaccustomed to giving.

Admission, Transfer, and Discharge

(Chapter 3)

1. The law requires the medical record to state the section under which the person was admitted and any changes in his status. (Sec. 3-202)

2. Patients may still be accepted on a *Voluntary basis*. (Sec. 3-401) The application form "shall contain in large, bold-face type a statement in simple nontechnical terms that the voluntary patient may be discharged from the facility at the

earliest appropriate time, not to exceed five days, excluding Saturdays, Sundays, and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and two certificates are filed with the court asserting that the patient is subject to involuntary admission." At the time of admission, "a copy of the application form shall be given to the patient and

to any parent, guardian, relative, attorney, or friend who accompanied the patient to the facility." This will probably necessitate a change in the admission procedures of most psychiatric facilities in Illinois. Another change is that after 20 days, application for voluntary admission must be renewed and "noted in the patient's record." This must happen *every 60 days* thereafter—if it doesn't, this "shall constitute notice of his (the patient's) desire to be discharged." (Sec. 3-404) The code (Sec. 402) essentially forbids threatening a patient with involuntary hospitalization "unless a physician, qualified examiner, or clinical psychologist who has examined the person is prepared to execute a certificate . . . and the person is advised that if he is admitted upon certification, he will be entitled to a court hearing . . ." within five working days.

3. "Informal admission" (Sec. 3-300) is allowed if accepted by the facility. These patients have the right to be discharged upon request during normal day shift hours. If a patient is admitted as voluntary (instead of informal), the record must state the reason why informal admission is not suitable.

4. The circumstances surrounding admission of minors (Article V) have been changed by the code. Any minor *age 14 or older* may receive outpatient counseling or psychotherapy *without consent of parent or guardian*. However, this counseling is limited to a maximum of five sessions, lasting a maximum of 45 minutes. (Sec. 3-501)

Any minor *age 16 or older* may be admitted as a voluntary patient. In these cases, the patient's parent or guardian "shall be immediately informed of the admission." Prior to admission, the minor must be personally examined by a psychiatrist or clinical psychologist. (Sec. 3-502)

Emergency admission of minors parallels that of adults. (See 5. below.) If parent or guardian cannot be found "after diligent effort" a minor may still be immediately hospitalized, if necessary. In these cases, "application of an interested person 18 years of age or older" is required. (Sec. 3-504) If no parent or guardian can be found in 3 working days, *or if that person refuses to consent to the admission*, "a petition shall be filed under the Juvenile Court Act to ensure that appropriate guardianship is provided." Renewal of authorization of admission for minors parallels that of adults—20 days after admission, then every 60 days.

Objections to admission of a minor are handled similarly to an adult objecting to his own admission—*i.e.*—a petition and two certificates

are required within five working days or the patient must be discharged. Minors 12 and over must be advised of their rights, just as adult patients are. Procedures for minors 12 and over generally parallel those of adult *Emergency Admissions*.

5. *Emergency Admission by Certification* (Article VI) is an important aspect of the code. This is the main part of the law which deals with involuntary hospitalization. For involuntary hospitalization, a petition and two certificates must be filed. (a) A petition can be filed by any citizen or peace officer. (b) A certificate must be "executed by a physician, qualified examiner, or clinical psychologist . . ." Personal examination of the patient is required *not more than 72 hours prior to admission*. It must contain "clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights." (Sec. 3-602) If a patient is held for examination on the basis of a petition alone, a certificate *must be furnished to or by the mental health facility within 24 hours*—if not, the patient must be immediately released. (Sec. 3-604 & 606)

Within 12 hours of admission, the patient is entitled to a copy of the petition and the address and phone number of the Guardianship and Mental Health Advocacy Commission. Within one working day, a copy must be given or sent to the patient's attorney, guardian, if any, and at least two other persons named by the patient. Also, the patient must be allowed to complete *at least two phone calls* at the time of admission. (Sec 3-609)

No later than 24 hours after admission (excluding Saturdays, Sundays, and holidays), the patient *must* be examined by a psychiatrist (not the same person who filled out the first certificate) and a second certificate must be completed. If this is not done, the patient must be immediately released. The hearing must be held within five working days of filing the petition and *first certificate*. It is important that at least one of the two certificates must be done by a psychiatrist. (Sec. 3-610)

6. *Court Hearings* (Article VIII) states that "To the extent practical, hearings shall be held in the mental health facility" where the patient is hospitalized. The code states that the patient "may have the proceedings transferred to the county of his residence." (Sec. 3-800) It seems to us that discretion must be exercised by the judge to avoid great inconvenience to the involved physician, psychiatrist, and mental health

(Suggested form to be given to patients)

R I G H T S

The following pages list some of your rights. You have other rights that concern procedures of admission and discharge. Those rights do not appear on these pages. However, you DO have a copy of those procedural rights; if you have admitted yourself voluntarily, look on the back of your voluntary or administrative application. If you are here involuntarily, look on the back of the Petition for Admission, and also look at both sides of any court orders you have received or may receive.

Rights of Recipients of Mental Health and Developmental Disabilities Service

- | | |
|--|---|
| Retention
of Rights | 1. As a general rule, you lose none of your rights, benefits, or privileges simply because you are a recipient of mental health or developmental disabilities services. For example, you do not lose your right to vote or to attend religious services. |
| Humane Care
Services Plan | 2. You are entitled to adequate and humane care and services in the least restrictive environment and an individual services plan. |
| Mail
Phone Calls
Visits | 3. You have the right to communicate with other people in private, without obstruction or censorship by the staff at the facility. This right includes mail, telephone calls, and visits. There are limits upon this right. They are:
(a) communication by these means may be reasonably restricted by the Director of the facility, but only to protect you or others from harm, harassment, or intimidation. |
| Property | 4. You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others.
When you are discharged, all lawful property must be returned to you. |
| Money | 5. You may use your money as you choose, unless you are under 18 or are under a court imposed restriction. |
| Banking | You may deposit your money at a bank or place it for safe keeping with the facility. If the facility deposits your money, any interest earned will be yours.

Neither this facility nor any of its employees may act as payee to receive any payment or assistance directed to you, including Social Security and pension, annuity, or trust fund payments without your informed consent. |
| Labor | 6. You must be paid for work you are asked to perform which benefits the facility. But note: You may be required to do personal housekeeping chores without being paid. |
| Refusing
Services | 7. You (or your guardian on your behalf) have the right to refuse services, including medication. If you refuse, you will not be given such services, except when necessary to prevent you from causing serious harm to yourself or others. |
| Restraints | 8. Restraints may be used only to protect you from physically harming yourself or others, or as a part of a medical/surgical procedure. |
| Seclusion | 9. Seclusion will only be used to prevent you from physically harming yourself or others. |
| Unusual
Services | 10. You will not receive electro-convulsive therapy (electroshock) without your informed consent.

Any unusual, hazardous, or experimental services require your written and informed consent. |
| Medical or
Dental Services | 11. Except in emergencies, no medical or dental services will be provided to you without your informed consent. |
| Restrictions
of Rights
Persons Notified | 12. If your rights are restricted, the facility must notify:
a) your parent or guardian, if you are under 18;
b) you and the person of your choice;
c) the Guardianship and Mental Health Advocacy Commission, if you say you want the Commission to be contacted. |

facility, if none are located in the patient's county of residence.

The patient is entitled to a six-person jury "on the question of whether he is subject to involuntary admission." (Sec. 3-802) He is also entitled to "an independent examination by a physician, qualified examiner, clinical psychologist, or other expert of his choice." (Sec. 3-804) He also has the right to be present at all hearings, unless waived by his attorney, and "the court is satisfied by a clear showing that the respondent's attendance would subject him to substantial risk of serious physical or emotional harm." (Sec. 3-800) At least one psychiatrist or clinical psychologist who has examined the patient must testify in person at the hearing.

An important aspect of the code is that the court may order treatment less restrictive than hospitalization. (Sec. 3-812) This offers much greater flexibility than the laws which are being superseded. The initial order for hospitalization shall not exceed 60 days. If the patient requires continued treatment, two new certificates and a new treatment plan must be filed. (Sec. 3-818)

7. *The Developmentally Disabled and Mentally Retarded* are also dealt with in the code, with great similarity of required procedures and documents. (Chapter IV) There are several changes regarding discharge and transfer of patients, but these mostly apply to facilities of the Illinois Department of Mental Health. (Article IX) . .

Summary

To summarize, these items must appear in the medical record:

1. The section the person was admitted under (informal, voluntary, emergency, etc.)
2. A statement that the patient was told of and given a copy of his rights.
3. Any restriction on patient rights, use of restraints or seclusion, and the reasons.
4. Why the patient was admitted as a "voluntary" rather than "informal" admission.
5. After 20 days of hospitalization, that the patient affirmed his desire for continued treatment.

In conclusion, Illinois citizens with serious mental illness requiring inpatient psychiatric care will continue to receive it in the state's public and private psychiatric institutions, as government cannot change clinical reality or illness frequency. Legislative impact upon mental health care policy through the new Illinois Mental Health Code is presently neither clearly defined nor immune from amendment. Mental health

leadership in Illinois must offset overly conservative and reactionary interpretations to the new mental health code by psychiatrists and other mental health practitioners. This could result in non-justifiable closures of small inpatient psychiatric units and an increasing resistance on the part of mental health professionals to care for seriously disturbed psychiatric patients, who are in need often times of involuntary treatment. The legislative leadership responsible for passage of the code has indicated a willingness to consider amendments to the mental health code as clinical and administrative data become available indicating need for change, as long as preservation of the balance between treatment needs and civil rights is maintained. Illinois physicians will again be called upon to counsel legislative bodies as a part of the process of maintaining the proper balance between the rights of the physician to treat and the rights of the state to regulate that practice in a free society. ◀

References

1. Van, J.: "Illinois Mental Case Code: Dignity, but it has a Price," *Chicago Tribune*, Sept. 17, 1978, p. 42.
2. Tourlentes, T.: "Illinois Mental Health Code—Proposals and Problems," *Illinois Medical Journal*, May 1977, 366-367.
3. Huey, K.: "A Mental Health Law Symposium on the Insanity Defense and Civil Commitment," *Hospital and Community Psychiatry*, 29(7): 443-449 (1978).
4. Spadoni, A.: "Legal Rights vs. Patient Needs," *Illinois Medical Journal*, Vol. 151(2): 86, 1977.

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Arrhythmias In Patients With Heart Disease During Fiberoptic Bronchoscopy

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The incidence and significance of ischemic changes and cardiac arrhythmias during Fiberoptic Bronchoscopy (FB) was evaluated in patients with and without heart disease by constant electrocardiographic monitoring (Holter). Of 17 patients without heart disease none had ischemic changes and 4 had a minor transitory arrhythmia. Eight of the 13 patients with heart disease had a minor transitory arrhythmia during FB. One patient with unstable angina pectoris developed ischemic changes necessitating discontinuation of FB. None had a major arrhythmia. FB can safely be performed in cardiac patients with adequate supplemental oxygen without the need for continuous monitoring. Only patients with unstable angina pectoris may warrant continuous ECG monitoring during FB.

Fiberoptic bronchoscopy (FB) is an invaluable diagnostic tool for physicians dealing with pulmonary disease. The ease of the procedure and

ability to visualize subsegmental bronchi have made it the procedure of choice in diagnosis and evaluation of endobronchial lesions, bronchopulmonary lavage and transbronchial biopsy procedures. As with any invasive diagnostic procedure, occasional complications arise. Knowledge of those factors predisposing to complications should enable one to avoid most of them and to deal more effectively with those that do arise. Reported complications of FB include hemorrhage, pneumothorax, arrhythmia, and reactions to topical anesthetics such as laryngospasm, seizures, and cardiovascular collapse.^{1,2} In a previous retrospective study, it was noted that most reported deaths during FB occurred in patients with underlying cardiovascular disease (usually ischemic heart disease), chronic lung disease, cancer or pneumonia.³ Twelve fatalities in 48,000 procedures were noted. Of these 12, hypoxia was suspect in 5, and excessive sedation was considered to play a role in 3.

The purpose of our study was to determine the incidence and significance of cardiac arrhythmias and ischemic S-T segment changes during FB and their contribution to morbidity or mortality.

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Patients with ischemic heart disease (IHD) are known to be more susceptible to arrhythmia and ischemic change during cardiovascular stress than patients without IHD. Since many of these patients may require FB for suspect intrabronchial neoplasm, it is important to know how "stressful" FB is in this group. Continuous electrocardiographic monitoring during FB allows an evaluation of its various phases: topical anesthesia, intubation, washing, brushing, biopsying, and extubation. If significant ischemic change or arrhythmia were noted in patients with ischemic heart disease during FB, then continuous ECG monitoring might be useful.

Materials And Methods

Thirty patients undergoing FB for various indications were studied. A complete clinical history was taken, emphasizing symptoms suggestive of ischemic heart disease or congestive heart failure. Current medications, resting electrocardiogram, electrolytes and other routine lab data were noted. An abnormal ECG was defined as any evidence of conduction defect, S-T segment or T wave abnormality or myocardial infarction pattern. Sinus tachycardia prior to or during FB was not considered a significant arrhythmia. All patients were premedicated with 0.5 mg. intramuscular atropine. In most cases, intramuscular meperidine was given one-half hour prior to the procedure. A continuous electrocardiographic monitor (Holter) was then attached to the patient and a simultaneous record of the subsequent FB events were recorded. Cetacaine spray was used as a topical anesthetic for the oropharynx and hypopharynx and 1-2cc. of 4% Lidocaine was injected via curved nozzle past the cords into the trachea. In an attempt to eliminate hypoxia as a factor in the study, oxygen at 3-4 liters/minute by nasal cannula was administered to all patients. Arterial blood gases were determined before, during and after the procedure. Intravenous diazepam was given intermittently for sustained, adequate sedation, and intubation with a 9mm. tracheal tube over an Olympus 5B2 fiberoptic bronchoscope was accomplished. The tracheal tube was left in place during the procedure. All bronchoscopic procedures were then completed, using Lidocaine diluted to approximately 1½ % for selective topical anesthesia. The amount of Lidocaine was limited to 400 mg. for the entire procedure.

The recording was screened for ST-T wave changes and arrhythmias. Arrhythmias were classified as major or minor. Major arrhythmias were defined as having potential to cause hemo-

dynamic compromise. They included severe sinus bradycardia (less than 40 beats per minute), atrial fibrillation with a rapid ventricular response (greater than 120 impulses per minute), supraventricular tachycardia (greater than 140 impulses per minute), premature ventricular contractions of Lown Grades 3 (more than 30/hour) and any other ventricular arrhythmia.^{3,4} Premature ventricular contractions (PVC's) of Lown's Grades 1 and 2 (less than 30/hour) were considered minor.

Results

Of the 30 patients studied, 13 had an abnormal pre-FB ECG. Ten of these 13 patients had ischemic heart disease by history (3 stable angina pectoris, 3 unstable angina pectoris and 4 other patients had old myocardial infarctions without recurrent angina). During FB, arterial blood gases at no time revealed a PO₂ of less than 60 torr and at no time did significant hypoventilation occur. No patient had significant electrolyte abnormalities, BUN elevation, or a hemoglobin less than 9gms%.

Table 1 compares the monitor results in those patients with an abnormal pre-FB ECG to those whose pre-FB ECG was normal. No major cardiac arrhythmia was recorded. Twelve of 30 patients (40%) had a minor arrhythmia during FB. Of these twelve patients 7 had 1-2 PVC's (Lown Gr. 1), 3 had frequent PVC's (Lown Gr. 2), 1 had a run of supraventricular tachycardia and 1 had both a run of supraventricular tachycardia and frequent PVC's of Lown's Grade 2. Four of the 17 patients with normal pre-FB ECG had a minor arrhythmia whereas 8 of 13 patients with abnormal pre-FB ECG had a minor arrhythmia during FB. Only one patient developed ischemic change (a 60-year-old white male with unstable angina pectoris). During intubation, S-T segment depression of 3mm. was noted on an ECG monitor in this patient. He indicated that he was experiencing anginal chest pains. When a crushed nitroglycerin tablet dissolved against his buccal mucosa gave no relief, he was extubated. The chest pains resolved within ten minutes and the S-T segment normalized in that time. Serial ECGs revealed no myocardial infarction, and subsequent cardiac catheterization documented severe three vessel coronary artery disease. In the 13 patients who developed ECG changes no FB event (intubation, biopsy, etc.) appeared to correlate with the appearance of an arrhythmia.

Table 1
Types Of ECG Change Observed During Fiberoptic Bronchoscopy

	No. of Patients	Minor Arrhythmias		Supraventricular Tachycardia	Major Arrhythmias	S-T Wave Changes
		1-3 PVC's Low Grade 1	<30 PVC's/hr. Low Grade 2			
Normal Pre-FB ECG	17	2	1	1	0	0
Abnormal Pre-FB ECG	13	5	3	1*	0	1
Total	30	7	4	2*	0	1

*One patient had both supraventricular tachycardia and frequent PVC's.

Discussion

The occurrence of endoscopically induced arrhythmias and ischemic change has been well documented in both gastroscopy and colonoscopy.^{5,6} Sixty-nine percent of patients with ischemic heart disease undergoing gastroscopy were noted to have ischemic cardiographic change, mainly during endoscope insertion. These ischemic episodes were occasionally of sufficient severity to warrant discontinuation of the procedure.⁵ During colonoscopy, the frequent occurrence of significant ventricular arrhythmias in patients with ischemic heart disease prompted the authors to recommend continuous ECG monitoring in such patients.⁶ Fiberoptic bronchoscopy, with the additional factor of airway intubation, might be assumed to be just as arrhythm or ischemia provoking as gastroscopy and colonoscopy. Our data does not confirm this hypothesis. Although 40% of our patients had a minor arrhythmia during FB, none were life threatening, *ie.*, no episodes of ventricular tachycardia, asystole or marked bradycardia occurred. Only one of our patients developed ischemic changes necessitating discontinuation of FB. He had both an abnormal pre-FB ECG and clinical evidence of unstable angina pectoris.

The lower incidence of ECG changes compared to that noted during gastroscopy would appear significant. Avoidance of hypoxia by routine use of supplemental oxygen, generally deeper level of sedation, and employment of Lidocaine as topical anesthetic are the factors that may be important for this difference. An increased number of arrhythmias during FB in patients who were hypoxic with a PO₂ level below 60 torr as compared to patients with levels

above 60 torr were observed by Shrader, *et al.*³ They reported an 11% incidence of major arrhythmias during FB which correlated significantly with hypoxemia. We found no major arrhythmias in our group of patients but none of our patients had PO₂ levels below 60 torr. We routinely used 3-4 liters of O₂ by nasal cannula while Shrader *et al.*, used 1-2 liters by nasal cannula. Lidocaine levels in blood achieved by its use as a topical anesthetic may also be a contributing factor in suppressing arrhythmias during FB. However, prior studies including the report by Shrader *et al.*, failed to show any statistically significant relationship between the incidence of cardiac arrhythmia and Lidocaine blood levels measured during bronchoscopy.³

The resting ECG had some value in predicting patients who might develop cardiac arrhythmias. Ten of 13 patients with abnormal resting ECG had ECG changes during FB. Nine had a minor arrhythmia and 1 had ST wave changes. Only 4 of 17 patients with normal pre-FB ECG had a minor arrhythmia. Despite increased incidence of arrhythmias noted in cardiac patients during FB, our study could not determine whether it is due to FB *per se*. Cardiac patients in general have increased incidence of arrhythmias. Without a prior base line monitoring we cannot conclude FB *per se* induced these arrhythmias. Our primary objective was to determine whether major arrhythmias occurred during bronchoscopy in patients with heart disease that would warrant continuous monitoring. Simultaneous work on this topic has recently been published with contradictory results. Shrader *et al.*,³ report an increased incidence of arrhythmias during FB, while Luck *et al.*,⁷ report a decrease in the

incidence of arrhythmias, compared to a base line monitoring in cardiac patients. Neither of the studies had any patient with ST wave changes during FB. One of our patients with unstable angina had ST depression and angina during FB requiring discontinuation of the procedure.

Summary

It appears that prior knowledge of a patient's cardiac status is important in evaluating patients for FB. Those patients with no significant cardiac disease and a normal ECG have tolerated the procedure extremely well. The presence of cardiac disease should not deter one from performing a needed FB and probably does not necessitate cardiac monitoring. The proper level of sedation and avoidance of hypoxia by the use of supplemental oxygen are likely to be more important factors in avoiding arrhythmias during FB in these patients. Finally, even patients with accelerating or unstable angina pectoris may undergo FB if absolutely essential, but it would seem advisable that continuous cardiac monitoring equipment be employed. If evidence of

ischemic change develops and if conventional anti-anginal therapy does not revert the ischemic change, prompt discontinuation of the procedure may be indicated. ◀

References

1. Suratt, P.M., Smiddy, J.R., Gruber, P.: "Deaths and Complications Associated with Fiberoptic Bronchoscopy," *Chest* 69:747-751, 1976.
2. Adriani, J., Campbell, D.: "Fatalities Following Topical Application of Local Anesthesia to Mucus Membranes," *JAMA* 162:1527-1530, 1976.
3. Shrader, D.L., Lakshminarayan, S.: "The Effect of Fiberoptic Bronchoscopy on Cardiac Rhythm," *Chest* 73:821-824, 1978.
4. Lown, B., Wolf, M.: "Approaches to Sudden Death from Coronary Heart Disease," *Circulation* 44:130-142, 1971.
5. Fujita, R., Kumura, F.: "Arrhythmias and Ischemic Changes of the Heart Induced by Gastric Endoscopic Procedures," *Journ. Gastroent.* 64:44-48, 1975.
6. Vawter, M., Ruis, R., Alaama, A., Aronow, W.S., Dagradi, A.E.: "Electrocardiographic Monitoring During Colonoscopy," *Journ. Gastroent.* 63:155-157, 1975.
7. Luck, J.C., Messeder, O.H., Rubenstein, M.J., Morrissey, W.L., Engel, T.R.: "Arrhythmias from Fiberoptic Bronchoscopy," *Chest* 74:139-143, 1978.

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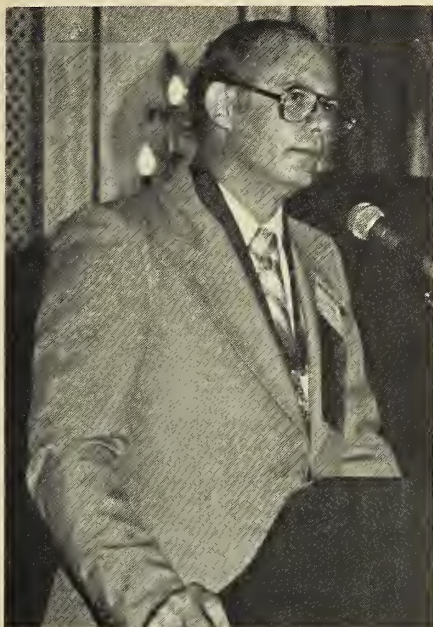
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1979

Convention



ISMS President P. John Seward, M.D., addresses the House of Delegates.

Summary



Retiring Speaker of the House Cyril C. Wigginshoff, M.D., (L) accepts plaque from Robert P. Johnson, M.D., the new speaker.

New Officers and Trustees . . .

Highlights of Convention '79 . . .

Summary of House Actions



ISMS House of Delegates confronts the issues of modern medicine.

Illinois State Medical Society

1979-80 Officers and Board of Trustees

Officers

PRESIDENT	P. John Seward, M.D., 310 N. Wyman, Rockford 61101
PRESIDENT-ELECT	Herschel Browns, M.D., 4600 N. Ravenswood, Chicago 60640
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2nd VICE-PRES.	B. Franklin Lounsbury, M.D., 927 Jackson, River Forest 60305
SEC.-TREAS.	Audley F. Connor, Jr., M.D., 7531 Stony Island, Chicago 60649
CHARIMAN, BOARD OF TRUSTEES	Robert R. Hartman, M.D., 1515A W. Walnut, Jacksonville 62650

House of Delegates

SPEAKER	Robert P. Johnson, M.D., 108 Maple Grove, Springfield 62707
VICE-SPEAKER	Clifton Reeder, M.D., 734 N. Merrill Ave., Park Ridge 60068

Trustees

1st District	1980	John Ring, M.D., 511 E. Hawley, Mundelein 60060
2nd District	1980	Allan L. Goslin, M.D., 712 N. Bloomington, Streator 61364
3rd District	1982	Alfred Clementi, M.D., 675 W. Central Rd., Arlington Hts. 60005
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	1981	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60649
	1981	Henrietta Herbolsheimer, M.D., 1700 E. 56th St., Chicago 60637
	1981	Lawrence L. Hirsch, M.D., 2434 Grace, Chicago 60618
	1980	Harold J. Lasky, M.D., 55 E. Washington, Chicago 60602
	1980	Richard Rovner, M.D., 645 N. Michigan, Ste. 920, Chicago 60611
	1980	Joseph Sherrick, M.D., 303 E. Superior, Chicago 60611
	1982	Cyril C. Wiggishoff, M.D., 25 E. Washington, Chicago 60602
4th District	1982	George Burke, M.D., Rock Island Franciscan Hospital, 2701 - 17th St., Rock Island 61201
5th District	1982	Robert Prentice, M.D., 2248 Warson Rd., Springfield 62704
6th District	1981	Robert R. Hartman, M.D., 1515A W. Walnut, Jacksonville 62650
7th District	1982	Alfred J. Kiessel, M.D., 1 Powers Lane Pl., Decatur 62522
8th District	1982	James Laidlaw, M.D., 104 W. Clark, Champaign 61820
9th District	1981	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th District	1981	Julian W. Buser, M.D., 6600 W. Main, Belleville 62223
11th District	1980	Kenneth A. Hurst, M.D., 52 Bunting Lane, Naperville 60540
12th District	1980	Joseph Perez, M.D., 5670 E. State, Rockford 61108

Trustee-at-

Large	1980	David S. Fox, M.D., 826 E. 61st St., Chicago 60637
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Highlights of the 1979 Annual Meeting

ISMS House of Delegates

The 139th Annual Meeting of the Illinois State Medical Society convened May 6-9, 1979, at the Palmer House, Chicago. Over 600 physicians, auxiliaries, medical students, guests and staff attended.

The Credentials Committee recorded attendance at the 1979 House of Delegates as follows:

	First Session	Second Session	Third Session	Fourth Session
Officers & Trustees	26	20	22	25
Speaker & Vice Speaker	2	2	2	2
Downstate Delegates	68	62	67	69
Chicago Medical Soc. Delegates	89	75	49	64
Intern/Residents	1	0	1	0
Student	2	0	1	0
TOTAL	188	159	142	160

The first session of the House of Delegates was convened by Cyril C. Wiggishoff, M.D., Speaker, at 1:00 p.m., on Sunday, May 6, 1979, ISMS Secretary-Treasurer, Audley F. Connor, M.D., conducted a brief memorial for the 156 members who died in the past year.

A commendatory resolution was adopted for Guy M. Pandola, M.D., former delegate from the Will-Grundy County Medical Society, who had resigned his position.

Jacob E. Reisch, M.D., Honorary President

At the Interim Session, the House had voted to elect Jacob E. Reisch, M.D., Honorary President of the Illinois State Medical Society. Dr. Reisch, who served from 1960-1977 as ISMS secretary-treasurer, is the only physician ever to receive this honor. His distinguished career as a practicing physician and a leader in organized medicine was cited. A former ISMS trustee and delegate to the AMA, Dr. Reisch served on numerous committees and councils beginning in 1947, and continues to direct the Society's annual public education booth at the Illinois State Fair.

Willard C. Scrivner, M.D., ISMS past president, presented the special award at the first session of the House of Delegates. "No physician has served this Society more faithfully, or is more deserving of the highest honor it can bestow, than Dr. Reisch," the citation read. "His tenure as ISMS secretary-treasurer was marked by a tireless dedication seldom, if ever, equalled by elected officials within organized medicine."

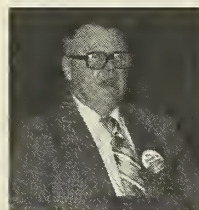


Jacob E. Reisch, M.D., (R) accepts Honorary President's Medallion from ISMS Past President Willard C. Scrivner, M.D.

"Success of the Illinois State Medical Society is no less than the sum of individual strengths," Dr. Scrivner said in presenting the award. "Those who have given their time and talents have become our benefactors . . . Dr. Reisch' tactfulness has spared many embarrassments through helpful suggestion."

Dr. Reisch accepted the commemorative plaque, and also an Honorary President's Medallion, to a standing ovation.

Report of the Chairman, ISMS Board of Trustees



Robert R. Hartman, M.D., chairman of the ISMS Board of Trustees, presented twelve reports on resolutions which had been referred from the Interim Session to the Board for study and report to the House. In addition, Dr. Hartman presented his written report, detailing Board action on matters forwarded for implementation. All issues referred has been addressed. Dr. Hartman's written report detailed activities in many areas. (For details on House action, please see "Old Business," in the Summary of Actions).

Reference Committees Convene

Reference Committees convened immediately upon House adjournment Sunday afternoon. Open hearings were conducted on 27 resolutions as well as reports from ISMS Councils and Committees, affiliate groups, and Illinois' governmental agencies.

A. Everett Joslyn, M.D., served as chairman for the Reference Committee on Constitution and Bylaws, where proposals related to peer review procedures, unified membership with the American Medical Association, and the ISMS Judicial Panel dominated discussion.

In Reference Committee A, Chairman Charles J. Jannings, III, M.D., guided consideration of resolutions and reports related to the activities of officers, and conduct of ISMS administration, finances and budget. The most extended debate centered on a proposal for representation of the Resident Physician Section on the Illinois delegation to the AMA. ICCME funding mechanisms and specialty society representation on ISMS councils and committees were also studied.

Government health programs, including national health insurance and cost containment, were areas of primary concern in Reference Committee B., chaired by Robert C. Hamilton, M.D. Suggested guidelines for ISMS negotiations with the Illinois Department of Public Aid were carefully reviewed, as well as reports from the Task Force on Cost Effectiveness, and several ISMS committees on health planning and relationships with government and third party payers.

Forrest H. Riordan, III, M.D., chaired Reference Committee C, where education, manpower and clinical medicine received primary focus. Alleged profiteering in continuing medical education courses, as well as a proposed policy statement on *in vitro* fertilization, were among issues confronted. A resolution condemning cigarette smoking, and demanding physician education of patients in that area, was strongly endorsed.

Earl Suckow, M.D., chaired Reference Committee D, concentrating on medical service and

economic matters outside government programs. Fuel allotments for physicians, to ensure availability of care in medical emergencies, as well as IDPH laboratory inspection regulations, were among resolutions discussed. A proposal for ISMS to catalyze regionalized blood banking in Illinois was addressed, as well as ISMS policy on usual, customary and reasonable reimbursement.

Governmental affairs and medical-legal matters were delegated to Reference Committee E, chaired by Thomas Meirink, M.D. Medical malpractice insurance, as well as activities of the Illinois State Medical Insurance Services, were considered. Possible amendment to Illinois' Good Samaritan legislation, as well as a progress report from the newly formed ISMS Judicial Panel, were studied.

Public relations, membership services and miscellaneous business were addressed by Reference Committee F, chaired by Donald Quinlan, M.D. The release of information gleaned in AMA survey poll results without opportunity for comment from the membership, and proposed political action organizations within county medical societies, were discussed.

At the conclusion of open hearings, each reference committee met in executive session to evaluate information and comment, and make recommendations for consideration by the House of Delegates.

ISMS Fifty Year Club Luncheon

133 physicians were inducted to the ISMS Fifty Year Club at a Monday afternoon luncheon. The Fifty Year Club now boasts some 950 members, who graduated from medical school at least fifty years ago. Joseph Keifer, M.D., professor emeritus of urology, UI Abraham Lincoln School of Medicine, and president of the Society of Medical History of Chicago, presented a talk on "Dr. Edmund Andrews, 19th Century Pioneer in Medicine and Science," to the 147 persons who attended. Dr. Andrews, who founded what is now the Northwestern University Medical Center, has been credited with major clinical advances in



Members of the ISMS Fifty Year Club.



ISMS Past Presidents (standing, l-r): Edward W. Cannady, M.D., Willard C. Scrivner, M.D., C. J. Jannings, III, M.D., Fredric D. Lake, M.D., Honorary Past President Jacob E. Reisch, M.D., George T. Wilkins, Jr., M.D., J. M. Ingalls, M.D., Joseph H. Skom, M.D., Newton DuPuy, M.D., and Edward A. Piszczek, M.D. Seated, l-r: Philip G. Thomsen, M.D., H. Close Hesseltine, M.D., Leo P. A. Sweeney, M.D., E. P. Coleman, M.D., J. Ernest Breed, M.D., and Caesar Portes, M.D.

diagnosis and treatment of urologic disorders.

ISMS Past Presidents' Dinner

On Saturday, May fifth, 16 of the 20 living ISMS past presidents gathered for the sixteenth annual Past Presidents' gourmet dinner at the Consulate Room of the Continental Plaza Hotel. After a reception in the President's Suite, the group gathered for dinner, and a special induction of Jacob E. Reisch, M.D. as permanent host and honorary past president. Joseph H. Skom, M.D., 1976-77 president, served as master of ceremonies, and inducted George T. Wilkins, M.D., as a member of the group.

Youth and Chemical Dependency

The ISMS Committee on Alcoholism and Drug Dependence, supported by a grant from the Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities, sponsored a seminar on Saturday afternoon, May 5, for interested physicians as well as the lay public. "Youth and Chemical Dependency," was co-chaired by Edward C. Senay, M.D., and Lee Gladstone, M.D. John E. Mayer, Ph.D., a psychologist affiliated with the Northwestern University School of Medicine, member of the youth division, citizens' advisory board on alcoholism, and a consultant to the National Institute on Alcohol Abuse and Alcoholism, served as guest speaker.

Dr. Senay provided an overview of youth and chemical dependency, as well as insight into substance abuse in the population as a whole. The constant is change in drug abuse treatment, he explained, as street combinations and availabilities continually fluctuate. Dr. Gladstone explored the vulnerability of adolescents to drugs, as well as psychosocial ramifications later in life. The largest problem, he said, is that young persons rarely experience physical after-effects common later in life. As a result, they give little credence to disease aspects of addiction. Describing typical feelings of alienation among adolescents, John E. Mayer, Ph.D., urged compassion. In treatment, he recommended, adolescent care focuses not on detoxification or particular substances—because quantities are usually small and physical dependencies minimal. The internal issues causing young persons to use substances, he said, provide the treatment focus.

ICCME Accreditation Workshop

The Illinois Council on Continuing Medical Education conducted the third annual workshop for CME accreditation surveyors on Monday, May 7. Participants reviewed a newly revised self-evaluation form for those seeking accreditation, and discussed the concept of overall program goals as a transitional step between needs identification and specified learning objectives. Program chairman Ward E. Perrin, D.O., guided



CME Accreditation Surveyors accept awards.

presentations and roundtable discussion.

Certificates of appreciation to the 35 physicians and six Ph.D.'s who had acted as accreditation site visit examiners in the past year were presented at the House of Delegates later that day.

Student Business Session Holds Annual Meeting

"Medical Education and Practice in a Pluralistic Society," was the topic of the annual Student Business Session seminar on Saturday, May 5. Joseph Giordano, DSW, director of the Lewis Caplan Center on Group Identity and Mental Health, Institute on Pluralism and Group Identity, American Jewish Committee, discussed the emergence of ethnic awareness in the 70's and its importance in evaluating community health needs. Irving Zola, Ph.D., professor of sociology, Brandeis University, considered cross-cultural differences in patients' presenting complaints. John P. Spiegel, M.D., former president of the American Psychiatric Association, and current director of the training program in Ethnicity and Mental Health, Florence Heller Graduate School of Advanced Study in Social Welfare, Brandeis University, lectured on training physicians for practice in a pluralistic society.

At the program's conclusion, the SBS held its annual meeting. Resolutions before the ISMS House of Delegates were discussed for the benefit of student delegates who would serve as SBS representatives. 1979-80 officers were elected: David Aizuss, chairman, Brad Epstein, vice chairman and treasurer, David Dries, secretary, David Whitney, delegate and Raj Paul, alternate delegate to the ISMS House.

"Establishing Yourself in Private Practice"

The ISMS Resident Physician Section sponsored a seminar on the above-captioned topic, conducted by Robert J. Kramer, M.D., on Saturday, May 5. The program was found particularly useful in providing guidelines for office management and in choosing a potential practice location.

At the conclusion of that meeting, the RPS Annual Business Meeting facilitated election of new officers for 1979-1980 as follows: Barry LeCompte, M.D., chairman, William Golden, M.D., delegate and vice-chairman, Linda Hughey, M.D., secretary/editor, and David Olive, M.D., alternate delegate. In his outgoing comments as 1978-1979 chairman, Ira Isaacson, M.D., stressed recruitment to the RPS, and encouraged participation at RPS Governing Council meetings.

ISMS Public Affairs-IMPAC Breakfast

The ISMS Public Affairs Committee and the Illinois Medical Political Action Committee jointly sponsored a breakfast for physicians and

auxiliaries on Monday, May 7. U.S. Senator Roger Jepsen (R-Iowa) discussed national health issues at the program, which was chaired by Don Hinderliter, M.D., chairman of the ISMS Public Affairs Committee.



Senator Jepsen gave an overview of U.S. foreign policy in recent years, referring to diplomatic relations with Iran and the African nations. Expressing concern regarding the U.S. role as a free world power, and responsibility to developing nations, Senator Jepsen encouraged physician involvement in the political process.

National health insurance, he said, should be viewed in terms of alternative plans. Speaking personally, he indicated possible support for a catastrophic coverage proposal.

The breakfast, attended by over 270 persons, also provided a forum for a film produced by the American Medical Political Action Committee, which is available to local physician and auxiliary groups. "Winning," documents the positive results of physician political involvement with an inside perspective on avenues to successful candidate support, and features Illinois physicians and their wives.

Former IMJ Editor Honored



T.R. Van Dellen, M.D., who served as editor and associate editor of the *IMJ* from 1949 through 1976, was presented a plaque expressing appreciation for his contributions to ISMS and improvement of patient care. Citing

his proficient and impartial conduct as editor, as well as "erudite and loyal service to this Society, devotion to advancement of medical science, the art of medical practice and quality of medical education," Robert R. Hartman, M.D., presented the award. Dr. Van Dellen accepted the plaque with characteristic modesty, to a standing ovation of the House.

AMA-ERF Check Presented

ISMS President David S. Fox, M.D., presented the 1979 AMA-ERF check to Morton C. Creditor, M.D., acting executive dean at the UI College of Medicine, representing the Illinois Council of Medical School Deans. This year's contribution for Illinois medical schools from the American Medical Association Education and Research Foundation represented an unrestricted grant of \$162,747.

Noting that U.S. physicians and auxiliaries had contributed \$1,354,000 to the national AMA-ERF fund this year, Dr. Creditor expressed deep

appreciation for the gift. "So very few funds are unrestricted," he said, "and can be used in so many sorely needed areas." Particularly emphasizing the role of auxiliary efforts in AMA-ERF activities, Dr. Creditor indicated that these funds would support scientific meetings, educational publications and a number of other improvements in medical education throughout the state.

IMPAC Reports

Herbert Sohn, M.D., chairman, presented the annual report of the Illinois Medical Political Action Committee to the House of Delegates. At present, he said, almost 5,000 physicians or nearly 50% of ISMS members, have joined IMPAC. Plans for the coming year include emphasis on the student sustaining membership and solicitation of medical specialty societies for membership.

IMPAC has won over 30 membership awards since 1970, Dr. Sohn said, noting that Illinois had pre-dated most PACs in the U.S., including those for industry and labor groups. "Physicians organized medical PACs to use their collective influence . . . at a time when it had become clear that individual influence wasn't enough," he said.

Dr. Sohn introduced Jack Lewis, M.D., chairman of the American Medical Political Action Committee, who presented two national awards to IMPAC. Illinois rated in first place this year for total women members. In candidate contributions, Illinois was second only to California.

Executive Administrator Report



Roger N. White, ISMS Executive Administrator, presented several issues of concern to the House, noting that these were more fully detailed in his written report.

A need to consider updating portions of the ISMS Policy Manual was becoming evident for legal reasons, Mr. White said. Reported investigations of late by the Federal Trade Commission indicated that it would be wise to examine the Manual and delete outdated portions. Some medical societies, Mr. White said, have instituted "sunset laws," reviewing all policies five years after implementation.

Mr. White's report reflected intense administrative activity. Areas of concern included acquisition and renovation of the new regional headquarters building in Springfield, as well as development of in-house computerized data processing services. Both had been accomplished in the past year.

Accelerated legal activity, particularly in conjunction with defense of a suit by several chiropractors, in which ISMS is joined with AMA and several other medical groups, had been ex-

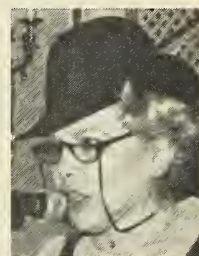
perienced this year. The Task Force on Professional Liability had maintained an aggressive posture in countersuits and other countermoves to litigation. IDPA and Medicaid related activities had proceeded at a rapid pace.

Mr. White reported that despite extension of the original five-year financial budget to six years, the deficit at end was smaller than had been anticipated. "If inflation doesn't overwhelm us," he added, "we fully expect to accomplish that plan."

Mr. White concluded his report with an appreciative note to the officers and Board of Trustees. "We are most fortunate," he said, "to have a highly dedicated group of physicians who are willing to serve in this capacity . . . I am proud to report that your Society is looked upon at both the national and state levels as one that is aggressive on behalf of its membership. This is due, in no small part, to the calibre of our leadership. Your staff is pleased and proud to be part of the team."

AAMA Reports Educational Activities

Leslie Lee, president, Illinois Society, American Association of Medical Assistants, was introduced to the House by John L. Wright, M.D., chairman of the AAMA national and state physician advisory boards. Mrs. Lee expressed appreciation



for ISMS' continued support of AAMA activities. Her report detailed extensive educational programs on office collections, medical office emergencies, CHAMPUS Services and clinical subjects. Their 23rd annual meeting had been held in April, Mrs. Lee said, and included excellent educational programs. "We extend an open invitation," she told the House, "to any interested physician who might like to inquire about our endeavors."

Auxiliary Reports Growth on Several Levels



Mrs. Earl V. Klaren, president, ISMS Auxiliary, reported on progress in the 51st year of organized activity. "Our motto this year has been 51 to grow on," Mrs. Klaren said. "Growth in partnership and in addressing community health needs through programs on nutrition, child abuse, education, and membership" (at a time when many auxiliaries are declining in members). "The auxiliary has grown in a variety of ways," Mrs. Klaren said, "including medical legislation, with final implementation of the Key Woman program." Growth and interest in benevolence also has been noted,

the president added, with over \$6,000 contributed this year. Auxiliary had again been at the top in AMA-ERF contributions, as well as AMPAC memberships.

Mrs. Klaren's report denoted a wide variety of community service and health education activities. Successful conferences for the northern and southern counties had been sponsored, as well as health fairs and multi-county conferences. Successful immunization awareness projects, vial of life and dual dues billings, were described. Health related scholarships, CPR training, family advocate programs for abused children and Encore programs for post mastectomy patients had been studied.

"Our prime goal," Mrs. Klaren reflected, "is to be your emissary of good will and liaison of fact to a largely misinformed public. The quality, equitable distribution, and preservation of free choice in medicine are, as always, goals we seek in partnership with you."

At the conclusion of Mrs. Klaren's report, the rules were suspended for a special resolution introduced by John J. Ring, M.D., 1st District Trustee. The resolution, adopted by acclamation of the House, commended Earl V. Klaren, M.D., former delegate from Lake County, who "unstintingly rendered service to his profession, often at great personal sacrifice, and always with good nature and devotion."

Report of the AMA Delegation

Herschel Browns, M.D., chairman, Illinois Delegation to the American Medical Association, introduced members of the delegation. Dr. Browns thanked them for a year of hard work and loyal effort.

Elected delegates to AMA were: Drs. Maynard Shapiro, Chicago; and George Wilkins, Jr., Granite City, who will fill the new delegate slot awarded to ISMS because of increased membership. Re-elected AMA delegates were: Drs. Herschel Browns, Chicago; Howard Burkhead, Evanston; Jack Gibbs, Canton; Morgan Meyer, Lombard; Joseph Skom, Winnetka; and Theodore Grevas, Rock Island.

Dr. Robert Hamilton, Chicago, was elected an AMA alternate delegate to fill the unexpired term of Dr. Andrew Thompson, Chicago, who resigned. Dr. Hamilton also was named to a full two-year term, and Dr. Clementi was elected to fill the newly-allotted alternate delegate slot. Also elected AMA alternate delegates were: Drs. Harold Lasky, Evanston; and Boyd McCracken, Jr., Greenville, who will fill Dr. Wilkins' alternate slot and also serve a full two-year term. Re-elected alternates were: Drs. Robert R. Hartman, Jacksonville, Lee Johnson, Litchfield; Eugene Johnson, Casey; Glen Tomlinson, Lincoln; and Cyril C. Wiggishoff, Northfield.

Dr. Browns announced that Theodore Grevas, M.D., had been elected to serve as delegation secretary. Jack L. Gibbs, M.D. received accolades denoting his four years of service as secretary and chairman of the delegation.

Dr. Browns announced that Fred Tworoger, M.D., was now retiring from membership on the AMA delegation. Dr. Tworoger's many years of service prompted a standing ovation from the House.

Dr. Browns referred to the report of the AMA Delegation, which noted that business in the past year had centered primarily on cost containment and national health insurance. The Illinois delegation introduced a total of 19 resolutions in the AMA House during 1978.

President's Valedictory



In his President's Address summarizing activities, David S. Fox, M.D., stressed physician involvement in containing health costs, and in health care planning.

During 1978, Dr. Fox reported, the nationwide rate of increase in hospital costs had dropped from 15.6% to 12.8%. In Illinois, under the direction of the Illinois State Cost Containment Committee (representing ISMS and IHA) the Voluntary Effort had helped reduce capital expenditures to \$356.9 million, or 63% of the previous three-year price-adjusted average, and



ISMS Delegation to the American Medical Association

reduced the rate of cost increases to 8.4% last year, down more than six percentage points from 1977.

Dr. Fox noted that duplication of such successes would be extremely difficult, but urged that each physician focus on cost savings. "We cannot lose sight of the fact that failure—or even limited success—will guarantee Congressional passage of the Administration bill," he said.

Dr. Fox discussed progress in opposing National Health Insurance proposals in the past year. Noting that catastrophic insurance bills were now under consideration, he reiterated the ISMS stand: "We are opposed to a government mandated program . . . and we are opposed to any steps which would move us closer to a comprehensive NHI system," he said.

In reference to health planning, Dr. Fox urged physician involvement. "The vast majority of Illinois physicians are not involved in local health planning," he said. "What can we expect if we don't get involved? I think we all know the answer to that question."

"Physicians' tendency to ignore health planning is unfortunate, but understandable. The law has not yet directly affected our practices. Efforts to extend certificate-of-need requirements to physicians' offices have failed. But the time is coming when health planning will have a significant impact on our practices. If we wait until then to become involved, it will be too late."

"Only you can serve on the HSA boards and committees . . . only you can present testimony expressing the local physician's view of your community's health needs . . . and only you can ensure that health plans will benefit rather than jeopardize patient care," he said.

Expressing appreciation for the contributions of ISMS officers, trustees, council and committee members, Dr. Fox concluded, "It has been a privilege and an honor to serve as your president. My colleagues, I thank you."

President's Night

On Tuesday evening, May eighth, 283 persons attended the annual gala dinner honoring David S. Fox, M.D., ISMS president. Howard Burkhead, M.D., served as master of ceremonies for the program, which included music by Franz Benteler & the Royal Strings, with dancing before dinner and into the evening.

Special Recognition

At the concluding session of the House of Delegates, Robert P. Johnson, M.D., who will now serve as Speaker of the House of Delegates, called Cyril C. Wiggishoff, M.D., to the podium. Dr. Wiggishoff received a plaque lauding "parliamentary excellence," in his term as Speaker, and noting his fair, good humored conduct in that office.



David S. Fox, M.D., (R) administers oath of office to P. John Seward, M.D., ISMS President.

P. John Seward, M.D., Inducted as 127th ISMS President

At the final session of the House on Wednesday, May 9, David S. Fox, M.D., administered the oath of office to P. John Seward, M.D., as 1979-80 president of the Illinois State Medical Society.

Dr. Seward called upon physicians to reaffirm respect for the medical profession, and in so doing, protect patients from low quality patient care administered by regulation.

"What makes a physician?" he asked. "Caring for pain and suffering of our fellow human beings . . . that is our privilege and responsibility. Ours is more than a job. It is a way of life . . . we are acutely aware of this responsibility."

"Our profession is not perfect," Dr. Seward said. "No segment of society can claim perfection. But we have dwelled too long on what is wrong. It is time to reflect on what is right . . . and how it best might be preserved, nurtured and improved."

Urging that "nothing—no institution, no third party, no government, stand between patient and physician," Dr. Seward described Orwellian scenarios for patient care, and cautioned that such warnings must not be considered inevitable. "Inevitability . . . is only a perception," he said. "We must create a different perception."

Noting contributions of medical practitioners dating to the Greeks, Dr. Seward again reiterated the primacy of quality patient care. "We must defend the privilege," he said, "the ability to treat patients without apology or servility to the political whims of the moment. Coersion is not a creative force. No idea, discovery, invention, insight or intuitive flash ever issued from a coercive edict."

"Dante said: 'The hottest place in hell is reserved for those who, in times of moral crisis, maintained their neutrality'."

"Let us persevere and preserve the principles of our profession," Dr. Seward urged. "Let us cede this privilege and responsibility to the next generation untarnished."

Summary of Actions

1979 Annual Meeting

House of Delegates

The ISMS House of Delegates met May 6-9, 1979, and acted on resolutions and reports as described below:

OLD BUSINESS

1. Amended the Bylaws to restrict areas of concern of the Council on Economics and Peer Review to: (a) ongoing relationships with third parties; and (b) health care costs and utilization. Peer Review was deleted from the Council's name and area of responsibility. (78N-15)
2. Deleted the statement on "fee schedules," from the ISMS Policy Manual because that matter is adequately covered in the AMA Principles of Medical Ethics. (78N-11)
3. Adopted the AMA position statement on second opinions for incorporation in the ISMS Policy Manual. (78N-42)
4. Requested that the Illinois Supreme Court establish, by rule, criteria which may be applied for identifying expert witnesses in civil cases. (78A-8)
5. Adopted physician advertising guidelines—adding to those endorsed by the House last November—which allow advertising of usual and customary fees for routine procedures and public announcement of fee changes. (Usual and customary fees in this context were defined as those fees charged to the majority of patients seeking the same basic service.) Average charges may not be stated, and fee identification must not be misleading. (78N-39)
6. Streamlined operation of the Interim Sessions of the House of Delegates by limiting business to urgent matters introduced by (a) the Board of Trustees; (b) the chairman of the AMA Delegation; and (c) individual delegates, when accepted by the Committee on Rules and Order of Business. The decision of that committee may be overruled by a majority vote of the House. Unaccepted resolutions will be carried over to the annual meeting. This change is effective immediately. (78N-19)
7. Mandated that information and resolutions involving ISMS dues and assessments be distributed to delegates and county medical societies at least 30 days prior to consideration. (78N-43)
8. Appointed an ad hoc committee to study proposed Bylaw revisions intended to clarify the duties and obligations of ISMS officers. (78N-47)
9. Deferred actions on proposals to: (A) seek legislation which would encourage medical schools to admit students on the basis of ability and merit; (b) gather and publicize information regarding costs borne by physi-

cians in complying with requirements of government health programs (c) establish a physicians' negotiating agency. (78N-1, 2, 46).

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. Defeated a proposed Bylaw amendment which would have made AMA membership optional for ISMS members. (79M-43)
2. Deleted from the Bylaws a provision for "Associate Members," because Illinois no longer provides for hospital permit physicians. (79M-10)
3. Expanded eligibility for ISMS council and committee membership with voting privileges to include students nominated by the Governing Council of the Student Business Session and residents nominated by the Governing Council of the Resident Physician Section who are approved by the ISMS Board of Trustees. Deleted reference to voting versus non-voting members of the Board of Trustees in consideration for council or committee appointments. (79M-11)
4. Amended the Bylaws to provide that, when a vacancy occurs on the ISMS Judicial Panel, the ISMS President shall nominate a successor to serve by appointment of the Board of Trustees until the next meeting of the House of Delegates, when the interim nominee may be elected to an appropriate term.

Further amended the Bylaws to provide that when fewer than three members of the Judicial Panel are able to participate in a particular Appellate Hearing, the ISMS President shall recommend to the Executive Committee of the Board of Trustees additional interim members to fill out the five-member Panel. Such interim members will serve only for the period of the pending appeal assigned. (79M-12)

5. Amended the Bylaws to establish the ISMS Peer Review Appeals Committee which will conduct all appellate hearings and be responsible to the Board of Trustees for monitoring and evaluating the performance of peer review functions of the ISMS at all levels. (79M-15)
6. Amended those sections of the Bylaws re-

garding peer review proceedings as follows:

The right to make an inquiry or complaint was extended to include physicians, patients and other parties. The right to appeal a component or district peer review committee decision was limited to ISMS members and patients involved. The bases upon which an appeal may be granted were limited to procedural error, bias and incomplete information, while the issue of "substantive error," was omitted. The right to appeal to the ISMS Peer Review Appeals Committee shall be limited to 30 days after the decision of the component society or district committee, but the appellant may attempt to obtain additional time if there is an acceptable reason for requested postponement. Possible action by the ISMS Peer Review Appeals Committee will include decisions to affirm, reverse, modify or remand. (79M-13)

7. Amended the Bylaws to provide that district committees may be assigned to act when the ethical relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of the Bylaws. (79M-14)
8. Defeated a proposed amendment to the Bylaws regarding the reporting of the official attendance record of the House. (79M-20)

REFERENCE COMMITTEE A

1. Directed that Illinois Council on Continuing Medical Education funding for 1980 be accomplished by the ISMS Board of Trustees in the same manner as for 1979, including half (\$10) of each dues-paying member's AMA-ERF contribution plus additional support from general funds, including provisions for contingencies, the total to be based upon needs as determined by the ISMS Finance Committee. Instructed ICCME to include in its annual report to the House of Delegates a financial report indicating: (a) major sources of income and categories of expenditure, and (b) a copy of the current budget. (79M-4)
2. Amended the Society's policy on specialty society representation on ISMS councils and committees to read as follows: "Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils." (79M-21)

3. Recommended that the AMA Delegation invite the Resident Physician Section to designate a resident physician member to fill any one vacancy in the downstate AMA alternate delegation at any AMA meeting, and the Student Business Session to designate a student member to fill any one vacancy in the Chicago Medical Society alternate delegation at any AMA meeting. Such designated resident or student member would continue to serve until the regularly elected alternate delegate was able to return. (79M-25)

REFERENCE COMMITTEE B

1. Accepted the following guidelines for negotiation with the Illinois Department of Public Aid:
 - * That the Department initiate adequate prior-to-payment ("front-end") review of claims.
 - * That the Department:
 - (a) Stop abuse of the audit process; (b) Audit for purposes of program integrity rather than as a substitute for adequate prior-to-payment review; (c) Refer all fraud cases to the Illinois Department of Law Enforcement; (d) Refrain from seeking a physician's financial records without subpoena.
 - * That the Department negotiate in good faith with the Illinois State Medical Society concerning a detailed audit protocol.
 - * That the Department not penalize a physician for failure to produce medical records without patient consent.
 - * That the Department cease using extrapolation.
 - * That the Department not "set-off" monies in cases which are under dispute until the administrative appeal process is exhausted.
 - * That the Department use an independent arbiter to serve as Hearing Officer during administrative review.
 - * That the Department honor requests for "discovery" entered by a physician undergoing administrative review.
 - * That only physicians acting in an advisory capacity to the Department have the authority to make medical judgments about the downgrading of given procedure codes.

The House further authorized negotiation of a Provider Agreement Form with IDPA, based upon existing ISMS policy and the above guidelines to be considered for rati-

fication by the House of Delegates. (79M-9)

2. Condemned the Department of Health Education and Welfare for the use of public funds for the arbitrary and discriminatory promotion of one type of health care delivery system over others. This was in reference to the alleged use of tax dollars to promote enrollment of Medicare eligibles in a particular HMO. The House also asked that a similar resolution be introduced at the next meeting of the AMA House of Delegates. (79M-27)

REFERENCE COMMITTEE C

1. Opposed profiteering involved in continuing medical education. Requested the Illinois AMA Delegation to introduce a resolution in the AMA House of Delegates directing AMA to seek a moratorium on complex computations of types and kinds of CME. (79M-7)
2. Did not adopt a resolution calling for ISMS opposition to the use of *in vitro* fertilization and embryo manipulation. (79M-22)
3. Discouraged smoking by recommending that physicians and their employees refrain from smoking during patient contacts. Also encouraged physicians to give advice and provide literature and signs concerning the health hazards of smoking. (79M-24)

REFERENCE COMMITTEE D

1. Adopted the policy that surgery to correct non-cosmetic post-surgical breast deformities is reconstructive surgery and therefore reimbursable. Requested that a similar resolution be forwarded to the AMA House of Delegates. (79M-1)
2. Directed ISMS to express disapproval to U.S. Senators and Representatives from Illinois regarding failure by the Department of Energy to provide reasonable fuel allotments for physicians in its plans to cope with the fuel crisis, noting possible deleterious effects on the availability and delivery of care to citizens in need. Instructed the AMA Delegation to introduce a similar resolution to the AMA House of Delegates, directing the AMA to work for amendment of the Department of Energy emergency fuel allocation plan. (79M-6)

3. Encouraged component societies to support abolition of blood bank replacement deposit fees. Urged ISMS and its component societies to: (a) encourage hospitals and other facilities to affiliate with a regional blood replacement center and (b) serve as a catalyst to assist appropriate organizations in establishing a regionally-coordinated blood banking system throughout and contiguous to the state. (79M-8)
4. Endorsed the AMA policy on Physician Reimbursement, which supports only the usual, customary and reasonable concept rather than any type of negotiated fee schedule. Requested the Illinois Delegation to AMA to introduce a resolution in the AMA House of Delegates calling upon AMA to reaffirm its support of the concept, and transmit same to the Dept. of HEW, Social Security Administration, and U.S. Congress. (79M-17)
5. Proposed that the Illinois Department of Public Health, through the Hospital Licensing Board and Division of Hospitals, Laboratories and Acute Care, recognize hospital laboratory accreditation by the College of American Pathologists' Inspection and Accreditation Program. Encouraged IDPH to discontinue the unnecessary, duplicative annual hospital laboratory accreditation program. (79M-19)
6. Defeated a resolution calling for legislative amendment requiring psychologist or social worker referral to physicians for medical conditions, because this implied a precedent of medical disorder management by non-medical personnel. (79M-26)
7. Referred to the Board of Trustees for appropriate action discrepancies in the annual report of the Illinois Department of Public Health. Noted items indicated that statutory boards are not being utilized properly and that certain actions of the Department appear to expand upon statutory authority.
8. Referred proposed "Sample Criteria Sets for Surgical Procedures," to the Board of Trustees for study and comment to the AMA. The referral added that the criteria, which seek to identify surgical procedures in terms of medical necessity and appropriateness, constitute a stricture on surgical practice.

REFERENCE COMMITTEE E

1. Supported the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category. (79M-18)
2. Adopted a policy statement to the effect that, when a physician performs emergency corrective procedures without compensation on a patient other than his own, and that patient is in distress due to a medical maloccurrence beyond the control or competency of the original attending physician, the second physician should be exempt from liability under Good Samaritan provisions, excepting cases of willful and wanton misconduct. Directed the Board of Trustees to seek introduction of legislation to this effect, provided this action would not jeopardize the existing Good Samaritan exemption. (79M-23)

REFERENCE COMMITTEE F

1. Defeated a resolution which called upon ISMS to assist county medical societies in establishing local political action organizations. (79M-5)
2. Requested the Illinois Delegation to introduce a resolution in the AMA House of Delegates that when the AMA reports survey results it should: (a) report facts and figures regarding both sides of issues in order to clearly define results; and (b) afford members an opportunity to comment prior to their publication. (79M-16)

SPECIAL ACTIONS

1. Commended Guy A. Pandola, M.D., former member of the House of Delegates from the Will-Grundy County Medical Society, who resigned for personal reasons. The House expressed gratitude for "generous expenditure of time and talent," wishing Dr. Pandola and his family "the best of health and happiness."
2. Expressed "profound appreciation" to Earl V. Klaren, M.D., former delegate from the Lake County Medical Society, who "un-
stintingly rendered service . . . often at great personal sacrifice, and always with good nature and devotion." ◀

Actions on Resolutions

May, 1979, Annual Meeting

House of Delegates

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Old Business			
78N-46 (BOT Report B)	George T. Wilkins, M.D.	Physicians' Negotiating Agency	Action Deferred until 1979 Interim Meeting
78N-15 (BOT Report C)	James Laidlaw, M.D.	Amendment to Chapter IX, Section 2, of the Bylaws Revising Areas of Concern of Council on Economics & Peer Review	Substitute Adopted
78N-11 (BOT Report D)	Lawrence L. Hirsch, M.D.	Deletion of Statement on Fee Schedules from Policy Manual	Adopted
78N-2 (BOT Report E)	M. B. Kirschenbaum, M.D.	Government Influence on Cost of Medical Care	Action Deferred until Board of Trustees Reviews Complete Study
78N-42 (BOT Report F)	Robert R. Hartman, M.D.	Second Opinion for Surgery	AMA Position on Second Opinion Adopted in Lieu of 78N-42
78A-8 (BOT Report G)	Ernest Adams, M.D.	Cost and Ethics of Malpractice Testimony	Substitute Adopted
78N-39 (Part II, items 11 & 12; Part III, items 8 & 10) (BOT Report H)	George T. Wilkins, M.D.	Physician Professional Advertising Guidelines	Section II, 11 & 12 Adopted; Section III, 8 & 10 Rejected
78N-1 (BOT Report I)	M. B. Kirschenbaum, M.D.	Medical School Admissions and Physician Shortage Areas	Action Deferred until 1979 Interim Meeting
78N-19 (BOT Report J)	P. John Seward, M.D.	Streamlining Operation of the Interim Session of the House of Delegates	Adopted as Amended
78N-43 (BOT Report K)	Ernest Adams, M.D.	Distribution of Information Regarding Dues & Assessments	Adopted
78N-47 (BOT Report L)	George T. Wilkins, M.D. Clifton Reeder, M.D.	Duties of the President	Referred to Special Ad Hoc Committee of the House of Delegates

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Reference Committee on Constitution & Bylaws			
79M-3	Richard Rudman, M.D.	Unified Membership with AMA	Not Adopted
79M-10	James Laidlaw, M.D.	Recommendation for Amending Chapter I, Section 1. MEMBERS	Adopted
79M-11	James Laidlaw, M.D.	Recommendation for Amending Chapter IX, Section 3	Adopted as Editorially Changed
79M-12	James Laidlaw, M.D.	Recommendations for Amending Chapter XI—Part 6	Adopted as Editorially Changed
79M-13	James Laidlaw, M.D.	Amendment to Chapter XII—Peer Review, by Substituting a New Chapter XII	Adopted as Amended & Editorially Changed
79M-14	James Laidlaw, M.D.	Amendment to Chapter VIII—District Committees	Adopted as Editorially Changed
79M-15	James Laidlaw, M.D.	Amendment to Chapter IX, Section 2 by Adding New Paragraph J	Adopted
79M-20	Lawrence Hirsch, M.D.	Recommendation for Amending Chapter IV, Section 7 of the ByLaws	Not Adopted
Reference Committee "A"			
79M-2	Ernest Adams, M.D.	Distribution of Information Regarding Dues & Assessments	Withdrawn
79M-4	Alfred Clementi, M.D.	Funding for the Illinois Council on Continuing Medical Education	Adopted
79M-21	Harold Lasky, M.D.	Revision in Policy Statement on Specialty Representation on ISMS Councils	Adopted
79M-25	James DeBord, M.D.	Resident Delegate from Illinois to AMA House of Delegates	Substitute Adopted
Reference Committee "B"			
79M-9	Finley Brown, Jr., M.D.	ISMS Policy on Medicaid	Substitute Adopted
79M-27	D. O. Chamberlain, M.D.	HMO Promotion under Medicare	Adopted as Amended
Reference Committee "C"			
79M-7	Clifton L. Reeder, M.D.	Continuing Medical Education	Adopted as Amended
79M-22	H. Frank Holman, M.D.	Prohibiting Bio-engineering	Not Adopted
79M-24	Kenneth Hurst, M.D.	Discouraging Smoking	Adopted

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Reference Committee "D"			
79M-1	Clifton L. Reeder, M.D.	Refusal of Third Party Payers to Pay for Reconstructive Surgery of the Breast to Correct Deformities	Adopted as Amended
79M-6	Mack W. Hollowell, M.D.	Lack of Special Gas Allotment for Physicians by the Department of Transportation	Adopted as Amended
79M-8	David S. Fox, M.D.	Blood Availability	1st RESOLVE—Adopted; 2nd RESOLVE—Adopted as Amended; 3rd RESOLVE—Substitute Adopted as Editorially Changed
79M-17	J. R. O'Donnell, M.D.	Usual, Customary & Reasonable Reimbursement	Adopted as Amended
79M-19	Morgan Meyer, M.D.	Inspection of Laboratories	Substitute Adopted
79M-26	Robert T. Fox, M.D.	Insurance Reimbursement of Non-Medical Professionals	Not Adopted

SPECIAL ITEM—Upon recommendation of Reference Committee "D," the House of Delegates directed the Board of Trustees to conduct an immediate, in-depth review of the proposed Sample Criteria Sets for Surgical Procedures and that appropriate response be forwarded to the AMA by June 10, 1979 as requested.

Reference Committee "E"

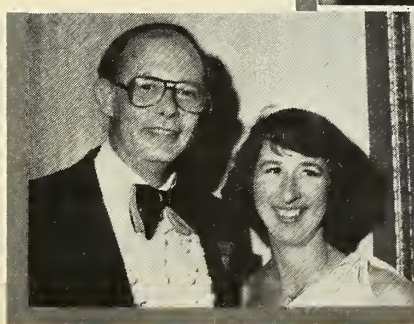
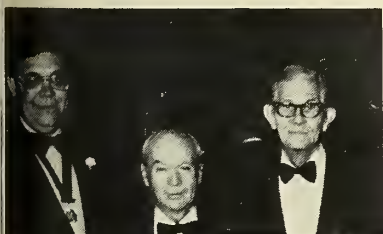
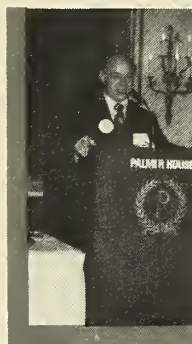
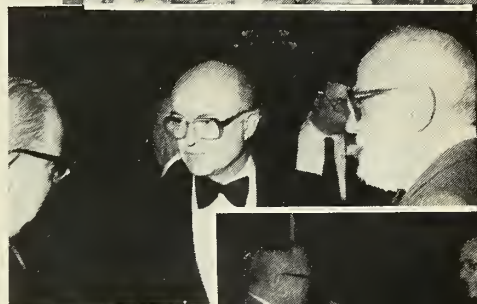
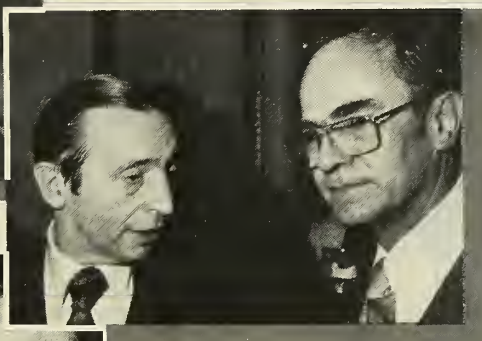
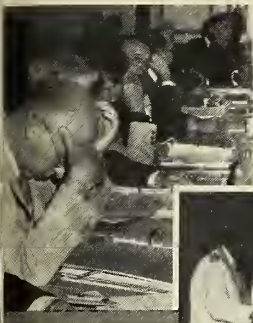
79M-18	R. M. Severino, M.D.	Equitable Risk Classifications in Medical Liability Premiums	Adopted
79M-23	David S. Fox, M.D.	Good Samaritan Law	Adopted as Amended

Reference Committee "F"

79M-5	Walter Brill, M.D.	County Medical Society Organization for Political Action	Not Adopted
79M-16	J. R. O'Donnell, M.D.	Survey Poll Results	Adopted as Amended

The following resolutions were considered by the House of Delegates without referral to a Reference Committee:

Robert J. Becker, M.D., Merle L. Otto, M.D., and Albert W. Ray, M.D. for Will-Grundy County Medical Society	Commendation for Guy A. Pandola, M.D.	Adopted
John J. Ring, M.D.	Commendation for Earl V. Klaren, M.D.	Adopted



Abstracts of Board Actions

(Continued from page 6)

downstate areas—to include Cook County. The U. of I. has indicated it no longer is interested in administering the program. Under the legislation, a physician administrator in the Department would direct the program, and a review board would be created to review his actions.

Psychotropic Drugs

ISMS will register an objection with the Illinois Department of Mental Health & Developmental Disabilities (IDMHDD) over a new IDMHDD regulation which limits the use of psychotropic drugs. The regulation infringes upon a physician's right to manage patient care by stipulating circumstances under which the drugs may be used to treat patients in IDMHDD facilities.

Elections/Nominations/Appointments

Sixth District Trustee *Dr. Robert Hartman*, Jacksonville, was re-elected Board Chairman.

Drs. Joseph Skom, Winnetka, and *Vincent Costanzo, Jr.*, Chicago, were appointed as the ISMS delegate and alternate delegate, respectively, to the 1980 Quinquennial Meeting of the U.S. Pharmacopoeial Convention this month in Washington, D.C.

Dr. Eugene Rogers, Chicago, was nominated for appointment to the IDPH Long Term Care Facilities Advisory Board, replacing *Dr. Robert Johnson*, Springfield, who resigned.

Nominated for appointment to the IDPA State Medical Advisory Committee were: *Drs. Joseph Perez*, Rockford; *James Reed*, Greenfield; and *Stanley Rousonelos*, Joliet.

Acting on behalf of ISMS—the sole shareholder in Illinois State Medical Insurance Services, Inc. (ISMIS)—the Board recommended the election of the following physicians to the ISMIS Board of Directors: *Drs. Alfred Clementi*, Arlington Heights; *Clifton Reeder*, Park Ridge; *Robert Hamilton*, Chicago; *Phillip Boren*, Carmi; *Warren Tuttle*, Harrisburg; and *J. M. Ingalls*, Paris; and *Mr. Roger White*, ISMS executive administrator. These individuals will be elected to the Board at the annual meeting of ISMIS shareholders on May 16. ◀

★
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Obituaries

****Ahstrom, James P.**, died June 7, 1979, at the age of 92. Dr. Ahstrom was a 1912 graduate of Bennet Medical College in Chicago.

***Godlowski, Zbigniew Z.**, Hinsdale, died May 29, 1979, at the age of 69. Dr. Godlowski was a 1930 graduate of the University of Cracov. He also was associated with Henrotin and St. Mary of Nazareth hospitals, and founder of the Copernicus Medical Research Foundation.

****Moser, Edward**, Oswego, died May 29, 1979, at the age of 89. Dr. Moser was a 1924 graduate of the University of Illinois.

***Stovall, Charley W.**, Peoria, died May 25, 1979, at the age of 43. Dr. Stovall was a 1960 graduate of the University of Illinois. He also was on the staff of St. Francis Hospital.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club

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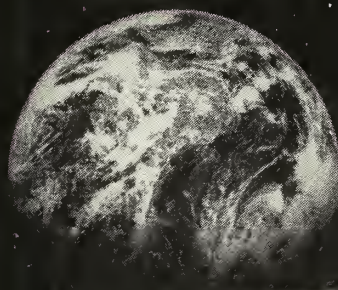
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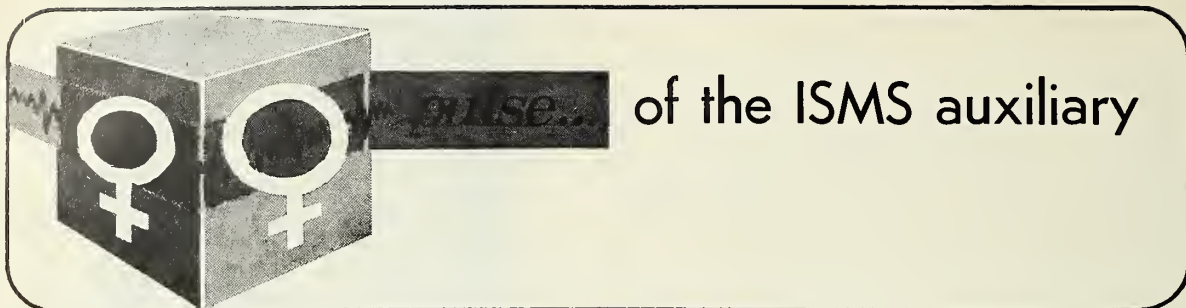
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BY MRS. R. S. HOOVER, ISMSA
PRESIDENT

Youth and Chemical Dependence

Eighty-five percent of high school seniors drink.

Twenty-six per cent of eighth graders have used marijuana.

Twenty-five-thousand deaths result annually from drunken driving accidents.

Alcohol is in some way responsible for over 50% of hospital admissions.

Illinois has the sixth highest rate of alcoholism out of the fifty states

Frightening statistics? There are more.

The percentage of people under 30 in Alcoholics Anonymous has increased by nearly 50% in three years and the percentage of women has rises by 32%, according to a survey of AA members in the US and Canada. Preliminary analysis showed that the percentage of young people in AA had increased from 7.6% in 1974 to 11.3% in 1977.

"Teenagers have more money to buy alcoholic drinks which are more accessible," says Walter Murphy on the National Council on Alcoholism. The problem begins earlier, but so does detection. Teenagers turn to AA, he said, "when older people offer them acceptance, support and stability—things they have always lacked." The AA study also reports that drug addiction is a problem for the group's female members and the under-30 age group. The percentage of young people dually addicted is 43%, compared to 18% for the total sample.

Estimates of authorities range to reporting that 27% of teenagers misuse alcohol. Many doses are very small, but the long range dangers great. Young people may not experience adolescence fully—how to deal with peers, develop personal relationships, sexual relationships, or just plain

learn technological skills or information basic to adulthood. Complicating the matter, young people tend to experience multiple drug abuse, combining alcohol with other drugs, such as marijuana. The disease of alcoholism has a very rapid progression in teenagers, possibly because of multi-chemical abuse. Teenagers seem to show a disregard for risk factors—they are willing to try anything. This loss of judgment may be a direct result of the brain's response to brain dysfunction due to alcohol toxicity. Begun at early adolescence, drinking may cause the teenager to believe that being "high" is the way of feeling normal, according to Dr. George Wendell, chairman, Alcohol Rehabilitation Committee, Highland Park Hospital.

Some indicators of alcohol use/abuse among youth follow. Abuse is defined as any pattern or non-therapeutic use of alcohol which interferes with one or more of the following:

- 1) Physical health (blackouts, hangovers, increased tolerance)
- 2) Psychological development (drink when sad, nervous, worried, angry, alone)
- 3) Social adaptation with family or peer group (major conflicts with parents, seri-

ous fights, drinks more than friends, loses friends, trouble with police)

- 4) Educational performance (drinking during school, interferes with school work, trouble with school authorities, drop out)
- 5) Occupational functioning (loss of job).

Don Newcombe, former major league pitcher and representative of the National Institute on Alcohol Abuse and Alcoholism, speaking at a recent workshop on Teen Age Alcoholism, listed these seven deadly sins of drinking:

- Drinking and driving
- Drinking when angry
- Drinking when tense
- Drinking while depressed
- Drinking on an empty stomach
- Drinking and having an argument
- Mixing alcohol with other drugs.

Teenagers are just as prone to these irresponsible alcohol-related behaviors as adults. Rationalizing drinking by such comments as, "I just need one more to relax," or "one for the road;" gulping drinks for stronger effect; celebrating by drinking every time things go well; drinking alone to escape boredom or loneliness; and drinking just to get drunk, are more irresponsible drinking behaviors.

What can we do? Can we teach our children how to drink? Can we give them correct and accurate information about alcohol and other drugs? What can we do to dispel the myths of advertising—the glamorous image, the virile macho man? Can we help our teenagers to deal with peer pressure? Most importantly, can we keep them out of the driver's seat if they have been drinking?

Twenty to thirty Americans die each day as a result of drunken driving accidents. Over 50% of automobile accidents and 90% of small craft (boat) accidents have an alcohol related factor as a cause. Most people seem to believe that drinking and driving is unacceptable only when it results in an accident that affects a friend or a relative. Isn't it time to do something about this? Dr. Henry Betts, medical director of the Rehabilitation Institute of Chicago, told the Illinois Senate Executive Committee that spinal injuries and brain damage to teens—from auto accidents caused by drinking—have reached epidemic proportions. Illinois may return the drinking age to 21—can we tighten up the law enforcement

procedures for drunken driving too?

Some hints for parents of teenagers: Watch your drinking as your children watch it. Don't overdrink; show that you admire people who drink sanely. Try not to overemphasize or glamorize drinking. Tell teenagers that most people drink in a spirit of fellowship, as opposed to drinking to escape problems. Point up the dangers of alcohol here and now. Teenagers can understand a drunk driving accident; it has more impact than tales of illness and degradation in later life. Have them see an educational film or attend a discussion on alcohol or drug related problems. Get closer to your children. Get expert help immediately if a problem develops in your family.

Peer groups such as Operation Snowball in Rockford and Northwest Illinois, and Reflections in Lake County, endeavor to promote positive peer leadership. An outgrowth of a program of the Illinois Teen Age Institute, Operation Snowball has been enormously successful—presenting programs to health classes, working with drop outs and problem teenagers, manning a crisis telephone line, sponsoring workshops—literally, kids helping other kids. Could your auxiliary help or sponsor a similar local group?

The Department of Health, Education and Welfare will be spending \$22,000,000 this year in an effort to combat the increasing problem of alcoholism and chemical dependence. Funds will be channelled into educational programs, treatment, prevention and research. Watch for new and varied programs; the auxiliary may be able to assist at the local county level. Remember too, that the ISMS Committee on Alcoholism and Drug Dependence has a Scientific Speakers Bureau which offers a wide range of continuing education programs at no cost, focusing on alcoholism detection and treatment. Could a program such as this be used in your area for a combined Medical Society/Auxiliary meeting?

To date, Cook, McLean, and Vermilion counties have in some way tried to do something about this growing and frightening problem of alcoholism and drug dependence among our youth. Has your auxiliary sponsored a workshop or program? Worked with the health educators in your schools? Sponsored a public education program? The AMA Auxiliary, ISMS Committee on Alcoholism and Drug Dependence, the National Council on Alcoholism, the National Parent Teachers Association, and the ISMS Auxiliary Health Projects Committee have materials and speakers available. Call them: they will help! ◀

Report of the Illinois Dangerous Drugs Commission

Survey of Emergency Room Drug Episodes

The Illinois Dangerous Drugs Commission recently reported results of their survey of Illinois hospitals regarding Emergency Room Drug Episodes in 1976 and 1977. Of 265 hospitals surveyed, 169 (63.8%) responded and provided information on 10,159 drug-related emergencies in 1977 and 9,301 in 1976. Their summary of results follows. For regional classifications, please refer to the map reprinted at right.

Single Drug Ingestions (3,988 incidents in 1977) Thirty-nine percent of all reported drug overdose episodes involved single drug ingestion both in 1976 and again in 1977. However, the rate of increase for single drug ingestions during this two year period averages only 9% whereas multiple drug ingestions and drug/alcohol combination episodes have each increased by over 20%.

Combinations of Drugs (1,989 incidents in 1977) Regions 2, 3B, 4 and 5 showed the most significant increases in emergency room episodes for overdose from drug combinations between 1976 and 1977. In Chicago, Talwin and Pyribenzamine ("T's and Blues") overdoses alone increased by 206% during this same time period.

Alcohol/Drug Combinations (1,246 incidents in 1977)

The greatest proportion of increase between 1976 and 1977 occurred in Chicago (+47%) although Regions 1A and 3B also reflected significant increases during this time period. It is important to note that Region 5 reflected 63% decrease in this type of episode for the same period.

Narcotics (656 incidents in 1977)

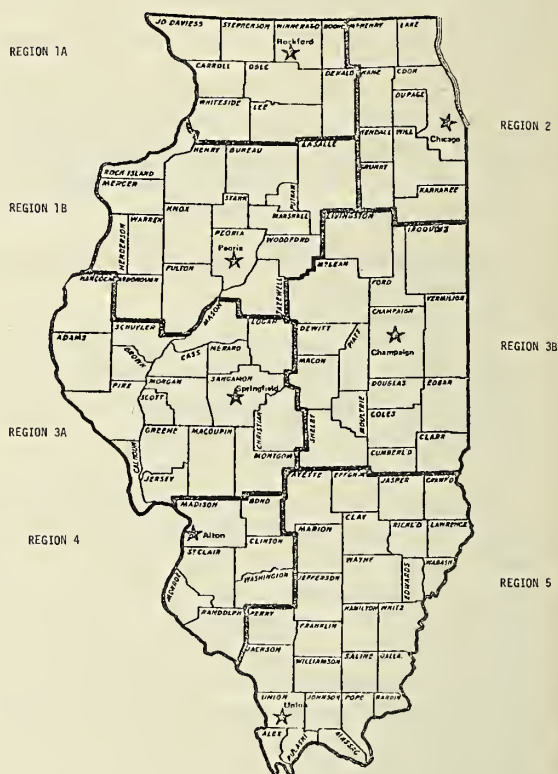
In general, heroin overdoses remained stable between 1976 and 1977 while methadone overdoses increased by 111%. Over 80% of all narcotic overdoses occurred in the Chicago metropolitan area, although Region 4 did show significant increases in heroin episodes during this time period.

Barbiturates (1,026 incidents in 1977)

Although Region 2 accounted for 64% of all 1977 barbiturate overdoses in the state, the highest proportionate increase occurred in Region 3.

Depressants (2,182 incidents in 1977)

More drug overdoses resulted from depressant



ingestion than any other single class of drugs. Chicago accounts for the majority of these emergencies with Regions 1A and 3B also significantly represented.

Amphetamines (214 incidents in 1977)

In general, amphetamine overdoses decreased between 1976 and 1977 although Regions 1A and 3B each doubled their number of reported emergency room episodes for this drug category during the past two years.

Stimulants (319 incidents in 1977)

Stimulant overdoses increased by 157% since 1976 with Region 2B reporting the largest number of episodes.

Hallucinogens (179 incidents in 1977)

The Chicago metropolitan area accounted for almost half of the total emergency room episodes for hallucinogen overdose, with the small cities downstate accounting for an equal distribution of the remaining episodes.

Inhalants (91 incidents in 1977)

Regions 1B, 2 and 3 showed substantial increases in emergency room episodes for inhalant abuse between 1976 and 1977, although butyl nitrite appeared only in Chicago city hospitals.

Marijuana (189 incidents in 1977)

All Regions except Region 4 reported increased marijuana related emergency room episodes between 1976 and 1977.

Phencyclidine (PCP) (452 incidents in 1977)

Average statewide emergency room episodes involving PCP increased by almost 30% between 1976 and 1977. However, Chicago experienced a 123% increase during this same time period.

Cocaine (73 incidents in 1977)

Statewide cocaine overdoses increased 28% between 1976 and 1977. However, most of these emergencies occurred in the Chicago metropolitan area.

T's and Blues (Talwin and Pyribenzamine) (192 incidents in 1977)

Overdose emergencies resulting from the use of T's and Blues increased 131% in 1977. Of the 192 total cases reported, 172 occurred in the Chicago area.

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Alcoholism and Related Psychiatric Illnesses

LEE SPALT, M.D./CARBONDALE

Associations of alcoholism with depression and antisocial personality have been reported. The present study of 37 alcoholic and 117 nonalcoholic psychiatric outpatients demonstrated more antisocial personality, nonprescription drug use, and organic brain syndromes in the alcoholic group. Other psychiatric disorders including the affective (depressive) disorders, schizophrenia, hysteria (Briquet's syndrome), anxiety neurosis, mental retardation, and sexual deviations were not shown to be related to either the presence or the absence of alcoholism.

After studying the work of Brugger,¹ Amark,² Bleuler,³ Guze *et al.*,⁴ and Winokur *et al.*,⁵ Goodwin wrote that "it appears there is an excess of depression, criminality, sociopathy, and abnormal personality in the families of alcoholics." Goodwin went on to report that alcoholism in probands was associated with de-

pression (in female relatives) and with alcoholism and sociopathy or antisocial personality (in male relatives). Alcoholism in probands was not associated with schizophrenia, mental retardation, mania or epilepsy (in their relatives).⁶

Hypotheses

It is hypothesized that alcoholic psychiatric patients have other psychiatric illnesses that differ in prevalence from those for nonalcoholic psychiatric patients. It is hypothesized that alcoholic psychiatric patients have more depression and antisocial personality than do nonalcoholic psychiatric patients.

Method

Comprehensive, structure interviews covering details of the Feighner, *et al.*, diagnostic criteria for psychiatric research^{7,8} were administered uniformly to every patient (154) seen for evaluation by this investigator during six consecutive



LEE H. SPALT, M.D., is a psychiatrist affiliated with the Southern Illinois University Student Health Programs in Carbondale, Illinois. Former associate professor in the department of Guidance and Educational Psychology at SIU, Dr. Spalt is affiliated with Memorial Hospital in Carbondale.

Table 1

Research Criteria For A Diagnosis Of Alcoholism

Group A

1. Have you experienced withdrawal symptoms (shakes, convulsions, hallucinations, DT's) when you have stopped drinking alcohol?
2. Have you had medical complications (liver, stomach, pancreas, muscle or nerve problems) from drinking alcohol?
3. Have you experienced blackouts (periods of amnesia not related to head injury) when you have been drinking heavily?
4. Have you gone on drinking binges or benders (drinking for 48 or more hours with neglect of your usual duties)? More than one bender is needed to score as positive.

Group B

1. Have you been unable to stop when you wanted to stop drinking?
2. Have you attempted to control your drinking by allowing yourself to drink alcohol only under certain circumstances?
3. Have you drunk alcohol before breakfast?
4. Have you drunk non-beverage alcohol (hair oil, mouthwash, Sterno, etc.) for its alcohol content?

Group C

1. Have you had arrests relating to drinking alcohol?
2. Have you had traffic difficulties related to your use of alcohol?
3. Have you had trouble at work or school because of your drinking?
4. Have you had fights associated with times that you have been drinking?

Group D

1. Have you thought that you drink too much alcohol?
2. Has your family objected to the amount of alcohol you drink?
3. Have you lost friends because of your drinking?
4. Have persons other than your family objected to the amount of alcohol you drink?
5. Have you felt guilty about your drinking?

months in a public/semiprivate psychiatric out-patient clinic attached to the Washington University School of Medicine and serving the metropolitan St. Louis, Missouri-Illinois area.

A diagnosis of definite alcoholism was made when symptoms were present in three of the four groups of symptoms outlined in Table 1. Probable alcoholism was diagnosed when symptoms were present in two of the four groups.

The study sample included both new and return patients from a variety of referral sources and was representative of the psychiatric clinic population. The significance of findings was tested by the chi-square and when appropriate the chi-square with the Yates correction method.

Results, Data, and Discussion

Table 2 presents psychiatric diagnoses other than alcoholism for the 37 alcoholic and the 117 nonalcoholic probands studied. The presence of alcoholism was associated with significantly more secondary affective disorder, antisocial personali-

ty, nonprescription drug use, and organic brain syndromes, and significantly fewer primary affective disorders than was the absence of alcoholism. The primary affective disorders were separated into two types. The unipolar type (depressions only) was significantly less often associated with alcoholism. The bipolar type (depressions and manias or manias only) was unrelated to the presence of alcoholism.

When all affective disorders (unipolar and bipolar primary affective disorders and secondary affective disorder) were considered together, no significant alcoholism-related differences were demonstrated. The alcoholism-related differences for the presence of unipolar primary affective disorder and secondary affective disorder could be a function of the definition of primary and secondary affective disorder. The presence of alcoholism prior to the onset of the affective disorder caused the affective disorder to be diagnosed as chronologically secondary to the onset of alcoholism.

Table 2
Other Psychiatric Diagnoses For Alcoholic And Nonalcoholic Psychiatric Patients

	Alcoholics			Nonalcoholics	
	37			117	
	N	%	p	N	%
Total affective disorders (primary and secondary combined)	31	84	NS	85	73
Secondary affective disorder	27	73	<.0005	29	25
Total primary affective disorders (Unipolar and bipolar combined)	4	11	<.0005	56	48
Unipolar primary affective disorder	2	5	<.001	39	33
Bipolar primary affective disorder	2	5	NS	17	15
Antisocial personality	15	41	<.0005	11	9
Nonprescription drug use	10	27	<.01	11	9
Hysteria (Briquet's syndrome)	5	14	NS	20	17
Anxiety neurosis	3	8	NS	5	4
Organic brain syndrome	3	8	<.05	2	2
Mental retardation	3	8	NS	5	4
Schizophrenia	3	8	NS	10	9
Schizo-affective illness	2	5	NS	5	4
Sexual deviation	2	5	NS	5	4
Phobic diseases	1	3	NS	1	1
Undiagnosed psychiatric illness	1	3	NS	8	7
Obsessive-compulsive disease	0	—	NS	1	1
No mental illness	0	—	NS	7	6

Patients with alcoholism were more likely to present histories fulfilling diagnostic criteria for antisocial personality (41% vs 9%, $p<.0005$) and for nonprescription drug use (27% vs 9%, $p<.01$). It is interesting to note that only a quarter of the alcoholics did give histories of drug use.

Sex-related differences for association of alcoholism with other psychiatric diagnoses were explored. Briquet's syndrome or hysteria was significantly different and was found only in women, a finding compatible with the expectations for Briquet's syndrome. There were no other diagnostic entities with sex-related differences for alcoholic probands.

Conclusions

Alcoholism was associated with increased incidences of antisocial personality, nonprescription drug use, and organic brain syndromes. Alcoholism was not associated with either increased or decreased incidences of affective disorder (primary and secondary combined) in general or bipolar primary affective disorder (manic-depressive illness) specifically. An association of

alcoholism with hysteria (Briquet's syndrome), anxiety neurosis, schizophrenia, schizo-affective illness, mental retardation, sexual deviation, obsessive-compulsive or phobic diseases could not be demonstrated. ◀

References

1. Brugger, C.Z.: *Familienuntersuchungen bei Alkohol-deliraten*; Z. Ges. Neurol. Psychiat., 151:740, 1934.
2. Amark, C.: "A Study in Alcoholism: Clinical, Social-Psychiatric and Genetic Investigations," *Acta. Psychiat. Neurol. Scand.*, suppl. 70, 1951.
3. Bleuler, M.: *Psychotische Belastung von Körperlich Kranken*, Z. Ges. Neurol. Psychiat., 142:780, 1932.
4. Guze, S., Wolfgram, E., McKinney, J.: "Psychiatric Illness in the Families of Convicted Criminals: A study of 519 First Degree Relatives," *Dis. Nerv. Syst.*, 28:651-659, 1967.
5. Winokur, G., Reich, T., Rimmer, J., et al.: "Alcoholism: III. Diagnosis and Familial Psychiatric Illness in 259 Alcoholic Probands," *Arch. Gen. Psychiat.*, 23:104-11, 1970.
6. Goodwin, D.: "Is Alcoholism Hereditary?" *Arch. Gen. Psychiat.*, 25:545-549, 1971.
7. Feighner, J., Robins, E., Guze, S., et al.: "Diagnostic Criteria for Use in Psychiatric Research," *Arch. Gen. Psychiat.*, 26:57-63, 1972.
8. Woodruff, R., Goodwin, D., Guze, S.: *Psychiatric Diagnosis*. New York, Oxford University Press, 1974.



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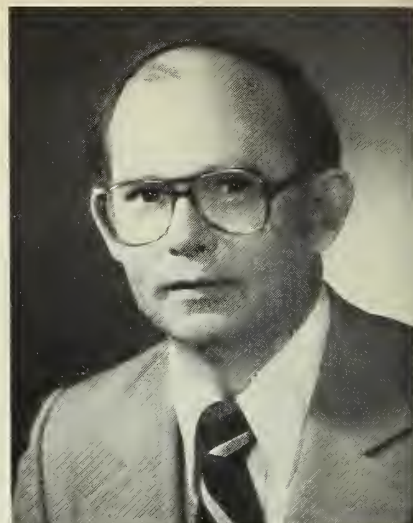
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Medicaid: At The Crossroads

"We learn geology the morning after the earthquake"

Ralph Waldo Emerson



Negotiation rapidly is becoming an integral part of medical practice. Unfortunately, physicians lack expertise in this exacting art, having been trained in problem solving techniques that follow logical patterns. The dichotomies developed during negotiation frequently are not bound by logical sequence and lack logical conclusions.

Theoretically, negotiation results in a reasonable compromise. In reality, negotiations in and of themselves never are "pure" because they may involve irreconcilable issues. This is an inherent snag when bargaining sessions focus upon mandates of the federal ethic.

ISMS currently faces this dilemma in negotiations with the Illinois Department of Public Aid (IDPA). The negotiations—which have spanned several years—are aimed at formulating a Provider Agreement Form which would spell out conditions for physicians participating in Medicaid. It appears that several key issues potentially may present difficulties in reaching a compromise:

- IDPA's unwavering demand for medical records without patient consent.
- IDPA's purely economic view of medical care versus the profession's commitment to high quality.
- IDPA's administrative policies and attitudes which fail to recognize the physician's professionalism and concern with quality care. These attitudes—appearing at times to be bureaucratically dispassionate—stem from IDPA's inefficient business practices and distorted perception of medical care delivery.

These issues threaten to reduce the current level of physician participation in Medicaid and prevent any expansion of physician involvement.

ISMS repeatedly has demonstrated its firm commitment to "good faith" bargaining which, hopefully, will produce solutions to many Medicaid problems. However, I assure you that ISMS never will accept a "settlement" which compromises professional ethics or standards.

The future of ISMS-IDPA negotiation remains clouded. There is a very real possibility that they will reach an impasse. IDPA must recognize the impact of its decisions on the delivery of high quality care. The negative results of IDPA's policies fall most heavily upon patients—those individuals the program is intended to assist.

The negotiations will determine whether IDPA can learn the lesson before the earthquake. ◀

A handwritten signature in dark ink, appearing to read "P. John Seward, M.D." with a stylized flourish at the end.

P. John Seward, M.D., President

Doctor's News

PHYSICIANS IN THE NEWS—Lawrence L. Hirsch, M.D., Chicago, professor and chairman of the Chicago Medical School Department of Family Medicine, was recently inaugurated president of the Chicago Medical Society. Dr. Hirsch is a member of the ISMS Board of Trustees, and chairman of the ISMS Policy Committee. Other newly installed CMS officers are Cyril C. Wiggishoff, M.D., immediate past speaker of the ISMS House of Delegates, president-elect, Alfred J. Clementi, M.D., member of the ISMS Board of Trustees, secretary, and John P. Harrod, Jr., M.D., who was re-elected CMS treasurer. Re-elected chairman of the CMS council was Robert C. Hamilton, M.D.; and Finley W. Brown, Jr., M.D., was re-elected vice-chairman of the council.

Joseph J. Muenster, M.D., Hinsdale, has been elected president of the Rush-Presbyterian-St. Luke's Medical Center medical staff. Dr. Muenster is senior attending physician in internal medicine and pediatrics. The other newly-elected medical staff officers at Rush are: Robert J. Jensik, M.D., Oak Brook, president-elect, Ernest W. Fordham, M.D., LaGrange, secretary and Leonard J. Hertko, M.D., Palos Heights, treasurer.

Henry W. Wiggins, Jr., M.D., Chicago, was recently appointed to the Chicago Board of Health. Dr. Wiggins is chairman of the department of Radiology and chief of the medical staff at St. Bernard Hospital in Chicago.

Nicholas J. Cotsonas, M.D., Peoria, has been named vice chancellor for academic affairs at the UI Medical Center in Chicago. Dr. Cotsonas served as dean of the Peoria School of Medicine since 1970. . . . Edward E. Gordon, M.D., director of the department of Rehabilitation Medicine at Alexian Brothers Medical Center in Elk Grove Village, recently received a Distinguished Service Award from the Association of Rehabilitation Facilities, based in Washington, D.C.

Tolbert Fanning Hill, M.D., Athens, received a medallion from the Rush Medical College Alumni Association, as the nation's oldest living physician. Dr. Hill, who practiced medicine until five years ago, graduated from medical school in 1896 and is Illinois' oldest physician.

The Chicago Society of Plastic Surgery recently awarded the Clarence Monroe prizes in clinical and research medicine to two Chicago-area resident physicians. David Katrana, M.D., Northwestern University, won the clinical prize, and Raphael Pollock, M.D., University of Chicago, was awarded the research recognition.

Edward P. Cohen, M.D., Chicago, was recently named dean of the School of Basic Medical Sciences at the UI College of Medicine in Chicago. Cornelius B. Bakker, M.D., was named head of the Peoria School of Medicine Department of Psychiatry.

Gerald S. Gotterer, M.D., is the new associate dean of Rush Medical College. Dr. Gotterer will serve as associate dean for Medical Student Programs.

ANTI-SMOKING REMINDER—The ISMS House of Delegates passed a resolution at the 1979 Annual Meeting encouraging physicians and their employees to refrain from smoking during patient contacts. The House further recommended that physicians advise their patients on the health hazards of smoking, and provide patient literature on the subject.

ISMS SPURS GENERAL ASSEMBLY ACTION TO HALT 'PILL PEDDLING'— Reacting to a *Chicago Tribune* expose that revealed widespread prescription abuse, the General Assembly adopted ISMS legislation to close loopholes in the law which allow physicians to improperly dispense amphetamines & other widely-abused drugs.

The ISMS proposals—amendments to a pending bill—represented a swift response to the Chicago-area scandal. The amendments would: (1) Require physicians who dispense—other than by administering—a Schedule II “controlled substance” in their offices to file a triplicate prescription form with the state; & (2) Move Preludin into Schedule II as a “designated product”.

The triplicate prescription form is required for all Schedule II “designated products.” When prescribed, the physician keeps one copy and gives the patient two copies. The pharmacist is responsible for forwarding the third copy to the Illinois Department of Registration and Education.

This ISMS-sponsored amendment provides for those instances in which a designated product is *dispensed directly*, by requiring that, in those instances, the *physician* is required to write up a triplicate prescription, and forward the third copy to the Department of R & E.

ISMS President Dr. John Seward also called on Gov. Thompson to sign another bill—passed earlier in the session—that would require more detailed record keeping by physicians who dispense any controlled substances in their offices. The legislation mandates physicians to keep a *detailed record* of each drug dispensed. Previously, only a gross inventory was required.

The *Tribune* expose detailed how some pill-peddling physicians & a so-called weight control clinic in Chicago had become a major source of “street drugs”. A Federal Drug Enforcement Administration official stated that diversion of drugs from doctors’ offices has become the nation’s major drug problem.

Dr. Seward urged the Dept. of Registration & Education’s Medical Disciplinary Board to immediately investigate, &, if warranted, take strong disciplinary action against physicians identified in the *Tribune* expose. R&E Dir. Joan Anderson subsequently indicated that a full-scale investigation was being launched into the physicians’ practices. Meanwhile, the Chicago Medical Society said it will consider censure, suspension & membership revocation of those mentioned in the series.

A LEGAL REMINDER—As a result of recent Chicago Tribune investigations of alleged practices at a Chicago clinic in violation of the Illinois Controlled Substances Act, and revelation of the fact that this clinic was owned by a non-physician, the Illinois Department of Registration and Education will be checking the charters of medical corporations licensed under the Illinois Medical Corporation Act.

That Act provides that *all* owners and shareholders of Medical Corporations in Illinois must be physicians licensed under the Illinois Medical Practice Act. ISMS members who are part of a medical corporation are urged to check their corporate charters and ensure that they are in compliance with the law in this regard.

MORE ON LICENSURE—Records at the Illinois Department of Registration and Education show that at present, 195 persons are registered as Physician’s Assistants, most of whom have Illinois addresses. Regulations for administration of the Illinois Physicians Assistants Act, currently being revised, require that a Physicians’ Assistant must identify to the Department the physician by whom employed, and physicians must identify to the Department the physician assistant they employ. Also, regulations require that physicians assistants perform only duties allowed under a protocol approved by the Department of Registration and Education. The Department has indicated that no such protocol has been approved. The Illinois Medical Examining Committee has asked that *IMJ* publish notice of this requirement, and remind employer-MD’s that diagnosis and prescription may be performed only by an M.D. and not by any physician extender.

Revised regulations will be available in early fall for public comment. Physicians may want to write the Department of Registration and Education for a copy in order to forward such comment. (The Department is located at 320 W. Washington Street, Springfield 62786.)

ILLINOIS STATE MEDICAL SOCIETY

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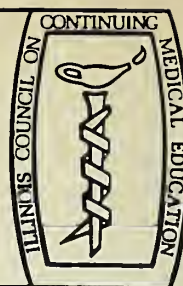
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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

August

Pediatric Dermatology

The Second International Congress of Pediatric Dermatology

For: Dermatologists, Pediatricians. Lectures/workshops, August 23-26, Chicago Marriott Hotel. Sponsor: University of Illinois at the Medical Center, Office of Cont. Educ. Services, 1855 W. Polk St., Room 144, Chicago 60612. Cosponsors: Abraham School of Medicine, Dept. of Dermatology; Int'l. Society of Pediatric Dermatology; American Society of Pediatric Dermatology; Chicago Dermatological Society. Reg. deadline: 8/1. Fee: \$205; \$175, members Int'l./Amer. Soc. of Ped. Derm. Credit: AMA Category 1, 27 hours. Contact: JoAnn Kohn. Phone: 312-996-8025.

Stress Pain Control/Holistic Medicine PROFESSIONAL INSIGHTS TO SELF-HEALTH

For: MD's, health care professionals. Workshop, Aug. 23-25, LaCrosse, WI. Sponsor: The Pain & Health Rehabilitation Center, Route #2, Welsh Caulee, LaCrosse, WI 54601. Cosponsor: Biogenic Institutes of America, Inc. Fee: \$150. Reg. limit: 20. Credit: AMA Category 2, 15 hours. Contact: C. Norman Shealy, MD. Phone: 608/786-0611.

Surgery

SPECIALTY REVIEW IN GENERAL SURGERY, PART II

For: Surgeons. Lecture, Aug. 13-24, Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$500. Reg. limit: 300. Credit: AMA Category 1, 99 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Ravenswood Hospital Medical Center Announces Its 2nd Annual Primary Care Conference August 15-17, 1979 Interlaken Lodge Lake Geneva, Wisconsin

The 1979 conference will deal with office problems in primary care medicine. For more information, call or write: Walter F. Kondratowicz, M.D., Dept. of Medical Education, Ravenswood Hospital Medical Center, 4550 North Winchester, Chicago, IL 60640. Phone: (312) 878-4300, x 4440.

September

Anesthesiology

EKG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. Lecture, Sept. 17 (5 days), Chicago. Speaker: Alon Winnie, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 35. Credit: AMA Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Dermatology

DIAGNOSIS AND TREATMENT OF SKIN DISEASE

For: GP's, Dermatologists. Lecture, Sept. 26, 1:30-4:30 p.m., Chicago. Speaker: Allan Larrinck, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago, IL 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Family Medicine

ADVANCES IN FAMILY MEDICINE

For: FP's. Lecture, Sept. 10 (5 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 125. Credit: AMA Category 1, 45 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Family Practice

ESSENTIALS OF ELECTROCARDIOGRAPHY

For: FP's. Lecture, Sept. 17 (5 days), Chicago. Speaker: Kenneth Rosen, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 50. Credit: AMA Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Internal Medicine/Cardiology

ECHOCARDIOGRAPHY (BASIC SEMINAR AND WORKSHOP)

For: Internists. Lecture, Sept. 12 (3 days), Chicago. Speaker: Neil Kramer, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 75. Credit: AMA Category 1, 22 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Neonatology & Perinatology

SPECIALTY REVIEW IN NEONATOLOGY & PERINATOLOGY

For: Pediatricians, OB/GYN, Anesthesiologists. Lecture, Sept. 24 (5 days), Chicago. Speaker: Dharmapuri Vidyasagar, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Neurology

NEUROLOGY, PART II, CLINICAL

For: Neurologists, Psychiatrists. Lecture, Sept. 24 (5 days), Chicago. Speakers: Sandra Olsen, MD., Frank Rubino, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 150. Credit: AMA Category 1, 42 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Obstetrics & Gynecology

SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY

For: Obstetricians, Gynecologists. Lecture, Sept. 10 (10 1/2 days), Chicago. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$400. Reg. limit: 200. Credit: AMA Category 1, 87 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Obstetrics/Gynecology

PEDIATRIC & ADOLESCENT GYNECOLOGY

For: Obstetricians, Gynecologists. Course, Sept. 14-15, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago, IL 60611. Cosponsor: Prentice Women's Hospital and Maternity Center. Fee: \$150. Credit: AMA Category 1, 8 hours. Contact: Patricia McClure. Phone: 312/649-8533.

Ophthalmology & Otolaryngology

Fall Meeting

For: Specialists in Oph. & Oto. Lectures, Sept. 15-16, Freeport. Sponsor: Illinois Society of Ophthalmology & Otolaryngology, 101 West North St., Danville, IL 61832. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: A. Reese Matteson, MD. Phone: 217-446-6410.

Otolaryngology

Annual Otolaryngologic Assembly

For: Otolaryngologists. Seminar, Sept. 16-21, The Towers Hotel, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Fee: \$400. Reg. limit: none. Credit: AMA Category 1, 42 hours. Contact: Jane Whitener. Phone: 312-996-8025.

Pediatrics

G.I. DISORDERS IN CHILDREN

For: MD's. Symposium, Sept. 13-14, St. Louis, MO., Sponsor, CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Reg. deadline: 9/6. Fee: \$150. Reg. limit: 140. Credit: AMA category 1, 10 1/2 hours; AOA, 10 1/2 hours; AAFP Prescribed, 10 1/2 hours. Contact: Loretta Giacometto. Phone: 314/367-9673.

Psychiatry

SEXUAL MEDICINE

For: Psychiatrists, Neurologists. Lecture, Sept. 24 (5 days), Chicago. Speaker: Dameena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 100. Credit: AMA Category 1, 43 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Rehabilitation

Canadian/American Seminar: Advances in Nerve Conduction Techniques

For: Psychiatrists, Electromyographers, Neurologists. Course, Sept. 5-7, Chicago. Speaker: Paul Kaplan, MD. Sponsor: Northwestern University Medical School, Rehabilitation Institute of Chicago, Dept. of Education & Training, 345 E. Superior St., Chicago, IL 60611. Cosponsor: American Academy of Physical Medicine & Rehabilitation. Reg. deadline: 8/20. Fee: \$150, physicians; \$100 residents. Reg. limit: 100. Credit: AMA Category 1, 14 hours. Contact: Don Olson, PhD. Phone: 312-649-6179.

Surgery

DISEASES OF THE BREAST—FIBROCYSTIC DISEASE OF THE BREAST

For: MD's. Symposium, Sept. 28, 11:15 a.m., Oak Park. Speaker: L. P. River, III, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

DISEASES OF THE BREAST—USE OF FINE NEEDLE BIOPSY & FROZEN SECTION AS A DIAGNOSTIC MODALITY

For: MD's. Symposium, Sept. 21, 11:15 a.m., Oak Park. Speaker: A. Zarif, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

DISEASES OF THE BREAST—DIAGNOSIS OF BREAST DISEASES USING MAMMOGRAPHY AS A MODALITY

For: MD's. Symposium, Sept. 14, 11:15 a.m., Oak Park. Speaker: Y. T. Ching, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

MANAGEMENT OF ACUTE HAND INJURIES AND SEQUELAE

For: MD's. Symposium, Sept. 29, St. Louis, MO. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Reg. deadline: 9/19. Fee: \$75. Reg. limit: 140. Credit: AMA Category 1, 6 1/2 hours; AOA, 6 1/2 hours; AAFP Prescribed, 6 1/2 hours. Contact: Loretta Gioacetto, Phone: 314/367-9673.

October

Alcoholism

SEMINAR SERIES ON ALCOHOL AND DRUG ABUSE

For: GP's, Internists, Psychiatrists. Seminar, Oct. 12-13, Sheraton Plaza, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Reg. limit: 150. Fee: \$50. Credit: AMA Category 1, 12 hours. Contact: Sue Karieneck. Phone: 312/996-8025.

Cancer

SIXTH ANNUAL CHICAGO SYMPOSIUM—"TUMOR PROGRESSION"

For: Oncologists, Internists, Surgeons, Hematologists. Symposium, Oct. 3-5, Pick Congress Hotel, Chicago. Speaker: Gordon Gutterman, MD. Sponsor: ITR Biomedical Research of the University of Illinois, 115 S. Sangamon St., Chicago, IL 60607. Cosponsors: Illinois Cancer Council, American Cancer Society. Reg. deadline: 9/28. Fee: \$75. Reg. limit: 200. Credit: AMA Category 1, 16 hours. Contact: Nancy Piekorski. Phone: 312/996-4688.

Internal Medicine

CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC & THROMBOTIC DISORDERS

For: Internists, Hematologists. Lecture, Oct. 19 (2 days), Chicago. Speaker: Hau Kwaan, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$150. Reg. limit: 100. Credit: AMA Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Pediatrics

PERSPECTIVES IN ADOLESCENT MEDICINE

For: Pediatricians, Generalists. Lecture, Oct. 31, 12:00 noon, Children's Memorial Hospital, Chicago. Speaker: Michael Cahen, MD. Sponsor: Children's Memorial Hospital. Fee: none. Reg. limit: none. Credit: AMA Category 1, 1 hour. Contact: Howard Traisman, MD, 1325 W. Haward St., Evanston, IL 60202. Phone: 312/869-4300.

Psychiatry

UPDATE IN PSYCHIATRY

For: Psychiatrists. Lecture, Oct. 8 (5 days), Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Radiography

QUALITY ASSURANCE EVALUATION OF THE RADIATION DEPARTMENT

For: Radiologists. Lecture, Oct. 11 (3 days), Chicago. Speaker: Theodore Fields, MS. Sponsor: Cook Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$250. Reg. limit: 75. Credit: AMA Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Radiology

A SEMINAR/WORKSHOP ON GENITO-URINARY RADIOLOGY

For: Radiologists. Workshop, Oct. 17-19, The Olympia, Ocanamowoc, WI. Sponsor: Dept. of CME, University of Wisconsin, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$235. Credit: AMA Category 1. Contact: Lyn Opelt. Phone: 608/263-2850.

IMAGING

For: GP's, Radiologists. Lecture, Oct. 17, Chicago. Speaker: Malcolm Cooper, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago, IL 60637. Reg. limit: none. Credit: AMA Category 1, 6 hours; AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Surgery

CLINICAL CONGRESS

For: Surgeons. Congress, Oct. 21-26, Chicago. Sponsor: American College of Surgeons, 55 E. Erie St., Chicago, IL 60611. Fee: varies. Credit: AMA Category 1. Contact: Dianne Currie. Phone: 312/664-4050.

Surgery

DISEASES OF THE BREAST—RADIATION THERAPY FOR CARCINOMA

For: MD's. Symposium, Oct. 5, 11:15 a.m., Oak Park. Speaker: William Brand, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

DISEASES OF THE BREAST—SURGERY FOR CARCINOMA OF THE BREAST

For: MD's. Symposium, Oct. 12, 11:15 a.m., Oak Park. Speaker: J. W. Tappe, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

DISEASES OF THE BREAST—CHEMOTHERAPY & HORMONAL THERAPY FOR CARCINOMA

For: MD's. Symposium, Oct. 19, 11:15 a.m., Oak Park. Speaker: William Ashley, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

DISEASES OF THE BREAST—PLASTIC SURGERY—USE AND ABUSE

For: MD's. Symposium, Oct. 26, 11:15 a.m., Oak Park. Speaker: A.A. Badri, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park, IL 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery

SPECIALTY REVIEW IN GENERAL SURGERY, PART I

For: General Surgeons. Lecture, Oct. 29 (11 days) Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$425. Reg. limit: 400. Credit: AMA Category 1, 94 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Surgery

ADVANCED PERIPHERAL VASCULAR SURGERY

For: Surgeons. Lecture, Oct. 15 (5 days), Chicago. Speaker: Jonh Bergan, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

RECENT CME ACCREDITATION RECOMMENDATIONS

The ISMS Committee on CME Accreditation has recommended to the Liaison Committee/CME approval of the CME programs of the following institutions:

Belleville Hospital Association
for CME
Columbus-Cuneo-Cabrini
Medical Center, Chicago
Illinois Central Community
Hospital, Chicago
Louise Burg Hospital,
Chicago
Ravenswood Hospital Medical
Center, Chicago
Riverside Hospital, Kankakee
St. Anne's Hospital, Chicago
St. Elizabeth Hospital, Granite City
Westlake Community Hospital,
Melrose Park
Woodlawn Hospital, Chicago

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BUNKER HILL: Rural community, trade area 3000. Doctor retiring. Living quarters and office space available. Excellent schools and churches. Fifty miles, north-east of St. Louis, Mo. Financial assistance available if necessary. Contact: Sally Bruckert, RR #1 Box 488, Bunker Hill 62014, 618-585-3192. (7)

DANVILLE: More than would be expected in a city of 43,000. Area population of 190,000 served by two medium sized community hospitals. An industrial medicine specialist or a neurosurgeon would find above average opportunities for professional growth. Area offers all the advantages of a smaller city life plus easy access to major urban areas. CONTACT: Richard V. Liven-good, President, Lakeview Medical Center, 812 North Logan Avenue, Danville, 61832. (9)

ELDORADO: Busy six-doctor practice looking for G.P./F.P., General Surgeon and Ophthalmologist. \$36,000 guaranteed first year. Located in town of 5000 in scenic southern Illinois. Call Dr. Elliott O. Partridge or Dr. Denton B. Ferrell, (618) 273-3361. (7)

FAIRFIELD: Need one family practitioner and one Gyn-OB man for an established two men (F.P. & Gen. Surgeon) practice in a 6500 population community. Drawing area 20,000. Excellent salary and fringe benefits. Very well equipped hospital. Excellent local schools and junior college. University 75 miles. Good recreational facilities and churches. Contact S. W. Konarski, M.D., 101 East Center Street, Fairfield, 618-842-2187. (7)

MATTOON: Family practitioner or internist for rewarding primary care practice. Fully equipped office available—New 210-bed hospital (open staff)—Financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient draw of 75,000. Contact: A. P. Rauwolf, M.D., 1120 Wabash, Mattoon, 61938. (217) 234-6253. (10)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensation negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

OQUAWKA: Population of County—8,000. Opening in new medical clinic. Ninety-five miles from Peoria. Complete office facilities. Near colleges. All recreational facilities nearby. CONTACT: HENDERSON COUNTY HEALTH DEPARTMENT, P.O. Box 186, Oquawka, 61469, (309) 867-2202. (10)

PITTSFIELD: Family Practitioner/General Practitioner/General Surgeon to join established practice or solo. Minimum guarantee, office space available free. 82 bed JCAH full service hospital. Great bird/duck hunting. Contact Gary Deer, Illini Community Hospital, 640 W. Washington Street, Pittsfield 62363; (217-285-2113.) (7)

SOUTHERN ILLINOIS: Opening in newly remodeled community Health Services Center located in Cairo adjacent to hospital. Target population 20,000. Six physicians, two dentists, counseling services, and outpatient lab at present. Financial assistance available. Near university and colleges. Wide range of recreational facilities. CONTACT: Steve Miller, 529 Cross St., Cairo 62914 (618) 734-4200 (8)

STERLING/ROCK FALLS: Primary Care physicians needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

SYCAMORE: Associate Desired—for July, 1980. Family practitioner to join two family physicians and internist in a newly formed group. Situated 112 kms west of Chicago in a semi-rural area. Family practice oriented hospital, with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D. (Director), 954 West State Street, Sycamore, 60178, (815) 895-9144. (9)

VANDALIA: County Hospital, serving population 25,000. Seven physicians at present. Sixty miles east of St. Louis on Interstate Highway I-70. Office space available on hospital campus. Financial assistance and deferred compensation agreements available. Contact John R. Leckrone, Administrator, Fayette County Hospital, 7th & Taylor, Vandalia 62471. (618) 283-1231. (7)

Physicians

The United States Air Force Medical Corps has immediate openings for primary care physicians. This is an opportunity to practice clinical medicine with 30 days of paid vacation each year. Ready for a change in lifestyle? Contact:

Capt. Stephen DeWoody
Air Force Recruiting Squadron
12th and Spruce Streets
St. Louis, Missouri 63102
Call Collect: 314-268-2471/2238

My

Political

Creed

I am a free citizen in a free nation.

Whoever diminishes my freedom as an individual diminishes the sum total of freedom in my country.

These things being true, I cannot--I will not--stand idly by when these hard-won freedoms are under attack.

I am also a physician, free thus far to treat my patients to the best of my ability.

Abridge that freedom and the health of my patients is adversely affected.

For I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

I believe that I, as a free citizen in a free land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

Therefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government.

Four-color reprints of the *Physicians' Political Creed*, suitable for framing are available to IMPAC members upon request by contacting IMPAC, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Viewbox

(Continued from page 10)

DIAGNOSIS: Carcinoid

Although the small bowel examination may demonstrate an abnormal mucosal pattern, in the other listed diagnostic possibilities these changes are usually much more extensive than demonstrated in the patient. In this instance the involved segment of ileum is relatively short with thick irregular folds. This is accompanied by narrowing of the lumen, kinking and displacement of adjacent normal bowel loops by thickened bowel wall; changes which are not seen in the incorrect choices. Similar changes however may be seen in Crohn's disease, tuberculosis, metastasis and lymphoma.

Carcinoid is the most common neoplasm of the small intestine but many are asymptomatic and not readily diagnosed on radiographic examination because of their small size. Approximately one-half of all carcinoids are found in the appendix. The vast majority of extra-appendiceal carcinoids are localized in the ileum, especially the distal portion, with smaller numbers distributed to the jejunum, duodenum, stomach, rectum,

pancreas and lungs. The peak incidence for carcinoid tumors is the fifth decade except for the appendiceal carcinoids which are discovered at an earlier age during abdominal exploration, or at the time of appendectomy.

When intestinal carcinoids become symptomatic the presentation is frequently that of obstruction as in the patient presented here, or as gastrointestinal blood loss. Occasionally patients will present with the carcinoid syndrome which usually implies extensive metastasis to the liver.

Because the initial growth of these tumors in the GI tract is submucosal, an intramural or intraluminal filling defect indistinguishable from other soft tissue neoplastic processes may be demonstrated radiographically. Single or multiple lesions may be present. Commonly, because of the desmoplastic reaction incited by the tumors, kinking, rigidity and bowel wall thickening may also be demonstrated. Mass effect may be present due to metastasis to lymph nodes. ◀

CORPORATE MEDICAL DIRECTOR

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The **Corporate Medical Director** will manage **FHP's** internal and external medical affairs through three Regional Medical Directors [California, Utah, Guam]. Peer level to Corporate Vice Presidents of Marketing, Operations and Finance.

Ideal Candidates will be licensed primary care Physicians with 5-15 years of Group practice experience interested in the **management** of innovative medical cost containment. Some experience directing the work of other Physicians is preferred.

For additional details, please call or send c.v. to:

Mr. James S. Siegal
Management Recruiting Department
[213] 429-2473, ext. 214

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1979-80 RPS Officers Elected

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

At the recent ISMS-RPS Annual Meeting, officers for the year to come were selected. The following people were elected to positions:

Barry LeCompte, Chairman. Dr. LeCompte will be a Senior Resident in neurosurgery at Rush-Pres-St. Luke's next year. He has been active in RPS activities over the past year, as well as in the AMA-RPS. President of the Rush House Staff Association, Dr. LeCompte has been instrumental in negotiating one of the best house staff contracts in the state.

William Golden, Delegate and Vice-Chairman. As a medical student, Dr. Golden served as AMA-SBS Delegate when he was at Baylor Medical Center. Now a medical resident at Rush-Pres-St. Luke's Medical Center, Dr. Golden will be on leave next year to be the Morris Fishbein Fellow in Medical Editing at the AMA.

Linda Hughey, Secretary/Editor. An OB/GYN resident at the University of Chicago, Dr. Hughey will serve in her second term as editor for the ISMS-RPS. This year she has also held the post of secretary-editor for the AMA-RPS.

David Olive, Alternate Delegate. Dr. Olive also hails from Baylor, where he has been the Chairperson of the Texas Medical Association student section. He plans to start his OB/GYN residency at Northwestern University in July.

Following the election of the new officers, outgoing chairman Ira Isaacson outlined plans for the upcoming year, focusing discussion on the problem of attracting the participation of residents from Peoria, Rockford and Springfield.

RPS Governing Council meetings are held at approximately monthly intervals at a time arranged to suit the convenience of anyone interested in coming. Information on upcoming meetings is available from Betty Duffy at the ISMS office. Meetings generally include a light supper and are always open to any interested resident.

Practice Management Seminar a Success

In conjunction with the Annual meeting, the ISMS-RPS sponsored and subsidized an all-day practice management seminar. The attendance of some 70 Illinois residents far exceeded the projected turnout. The participants came away with many useful ideas on office management and evaluation of potential practice sites. Based upon the enthused response, the RPS will no doubt sponsor future seminars. ◀

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- BASIC SEMINAR AND WORKSHOP IN ECHOCARDIOGRAPHY—September 12-14
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What I Have Gained As A Member Of AAMA, Illinois Society

BY LUELLA V. MITCHELL/CHICAGO

1956 was a very memorable year for me. That is the year I joined the Chicago Medical Assistants Association (American Association of Medical Assistants, Illinois Society, Chicago Chapter). As a member, I have become a more competent Medical Assistant.

In the days of "yore," doctors trained their own "girls." Today, where is the physician, even if he had the time, who can train his Medical Assistant in mastering dictating machines, accounting procedures, collections and credit, insurance forms, purchasing, telephone techniques, reception room courtesies, the inevitable complexities of computerized record keeping, patient histories, and how to handle patient personality problems that leave the Medical Assistant in tears and fury?

Further, where is the physician who has the time to tutor on anatomy, physiology, preparing patients for examination, professional law and ethics, and medical terminology?

Because I was a member of the Illinois Society, my physician-employer did not have to give his time in training, because learning is a part of membership.

I was encouraged by my physician-employer to become a member of the American Association

of Medical Assistants—an organization dedicated to improving Medical Assistants both educationally and professionally. He pays my dues and has expressed many times the enormous dividends he has received from his investments.

I used to be a "Girl Friday." Today a "Girl Friday" is as obsolete as yesterday's medical practice. With the increasing complexities in medical advances, the Medical Assistant **MUST** be qualified. The Medical Assistant is a member of the medical team, acutely aware that cooperation of every team member is necessary if patients are to receive the kind of service exemplified in the free enterprise system of American medicine.

If other doctors are interested in their Medical Assistants' deriving as many benefits as I have from being a member they will **INSIST** that their Medical Assistants become members of AAMA, Illinois Society.

For further information contact—Cissy A. Egly, CMA., 1413 S. Midland Court, Joliet, IL 60436 or Mrs. Luella Mitchell, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

(The history of the American Association of Medical Assistants will be continued in the next issue of the IMJ.)

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EKG

(Continued from page 8)

Answers: 1. A. 2. E.

The diagnosis of this ECG rhythm strip is best seen in lead II where the change in P wave contour can be appreciated. The fifth beat shows a negative P wave with a PR interval of 0.10 seconds. This beat and the next four beats are preceded by a negative P wave and have a cycle length that is nearly regular at 1080 milliseconds or a heart rate of 56 beats per minute. The sinus rate here is also slow at approximately 60 beats per minute. The R-R interval of the junctional pacemaker is usually constant and the QRS morphology is the same as in the sinus beats. A coronary sinus rhythm classically looks like this with inverted P waves but has a normal PR interval. The atrioventricular (AV) junction anatomically extends from the approaches to the AV node to the bifurcation of the bundle branches.

Location of the exact pacemaker site in this anatomic area is difficult using the clinical ECG. The appearance of the AV junctional rhythm is related to the rate of the junctional pacemaker relative to the rate of the sinus pacemaker. In our patient, slowing or arrest of the sinus pacemaker allowed the appearance of the slower junctional pacemaker. Some authors have called this a "passive" junctional rhythm to contrast it with the "active" or faster junctional tachycardias. Our patient's history suggested increased intracranial pressure and this may have played a part in her slow sinus rhythm. However, this rhythm can be seen in healthy people. It is usually a transient phenomenon that disappears when the sinus rate increases. No treatment is required. ◀

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Abstracts of Board Actions

June 14, 1979

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

APPOINTMENTS/NOMINATIONS

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1979-80. Appointed Council chairmen were: *Drs. Herbert Natof*, Highland Park, Economics; *Donald Pochyly*, North Chicago, Education & Manpower; *Howard Burkhead*, Evanston, Governmental Affairs; *Donald Aaronson*, Chicago, Medical Legal; *Shirley Roy*, Chicago, Medical Service; *Arthur Traugott*, Urbana, Mental Health & Addiction; and *Peter Vinciguerra*, Libertyville, Public Relations & Membership Services. The chairman of the Council on Affiliate Societies will be named at a later date.

The Board will nominate the following physicians for appointment to State bodies:

- *Drs. Raimundo Rodriguez*, Murphysboro; and *Levon Topouzian*, Skokie—reappointment to Medical Disciplinary Board.
- *Dr. Arthur Fischer*, Chicago—Medical Examining Committee.
- *Dr. William Lees*, Lincolnwood—reappointment to Illinois Hospital Licensing Board.
- *Dr. Herbert Dexheimer*, Belleville—IDPA State Medical Advisory Committee.

LOCAL PREPAYMENT PROGRAMS

Acting to assist local physician-sponsored prepayment programs, the Board voted to: (1) Respond positively to requests by physicians in the Springfield and Rockford areas to provide a responsive carrier and mechanism to support their prepayment objectives being pursued through Individual Practice Associations (IPAs); and (2) Make this new membership service available to other component medical organizations.

AMA RESOLUTIONS

The Board authorized the introduction of resolutions at the upcoming AMA Annual Meeting that would:

- Amend AMA Bylaws to require that selection of representatives to AMA Student Business Section meetings be made by AMA student members or state medical societies. The Bylaws currently allow selection of SBS representatives by medical school student bodies, which contain many non-members of AMA.
- Urge AMA to oppose a proposed Federal Trade Commission regulation that would prohibit physicians from serving on policy-making boards of organizations—such as foundations for medical care—involved in health care.

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On The Cover

The photo on our cover this month shows activity at the famous Koster Site, an archeological dig 50 miles north of St. Louis and 270 miles southwest of Chicago in Greene County, Illinois. To date, Koster is the largest, oldest and most complex of those sites excavated in the lower Illinois and Mississippi River Valleys by the Foundation for Illinois Archeology in collaboration with faculty from the Northwestern University Archeological Program.

Koster is one of 17 digs, each coordinated by researchers on the staff of the Kampsville Archeological Center, which has been termed the first permanent archeological teaching and research field campus on the continent. The location is designed to facilitate archeological exploration throughout a 2800 square mile area surrounding it, which includes the Koster Site.

Excavations there have found evidence to piece together cultural, artistic and subsistence activity dating to 7500 B.C. Sites of burials, villages and food storage areas, as well as utensils used in wood-working, cooking, farming and hunting have been unearthed by Illinois archeologists.

According to a recent publication by the Foundation for Illinois Archeology, the prehistoric record encompassed by the Kampsville Center project spans 12,000 years, and equals or exceeds that of any in the U.S. Archeologists at Koster uncovered remains of 14 separate communities layered one over the other, and pro-

tected by layers of rich soil accumulated during interim periods. The oldest layer, dated 7500 B.C., is 36 feet beneath the surface.

Stuart Struever, a professor of anthropology and archeology in the Department of Anthropology, Northwestern University and Chairman of the Board of the Foundation for Illinois Archeology, who first discovered the Koster Site, is credited with much of the progress there. Archeologists have described a series of cultures, preserved through the kindness of natural circumstance and documented through modern technique. Excavation began in 1969, when an Illinois farmer, Alec Helton (for whom the unidentified peoples are named) handed Struever several Indian spear points which he had found in a cornfield on the farm of his neighbor, Theodore Koster.

The Northwestern University Archeological Program offers adult education programs for interested persons, without prerequisite knowledge or expertise. Although the Koster Site has been closed, other activities and digs near the Kampsville Center offer many opportunities. Lectures, seminars, workshops and field trips are conducted, usually in one-week summer sessions at the Kampsville Center. For further information about tours and courses, contact Ms. Ellen Gantner, Northwestern Archeological Program, P.O. Box 1499, Evanston IL 60204.

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the fol-

lowing style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

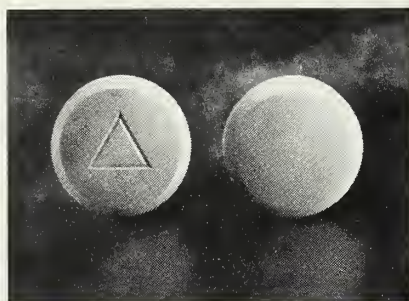
Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

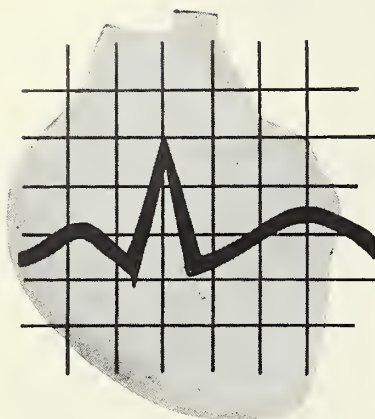
We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



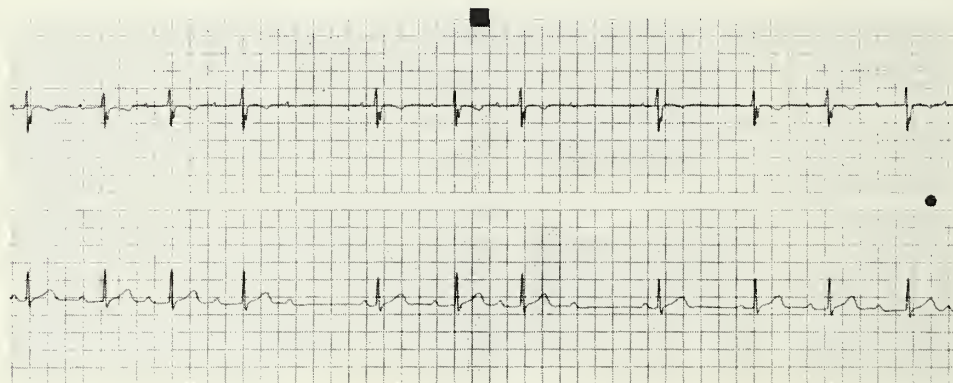
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

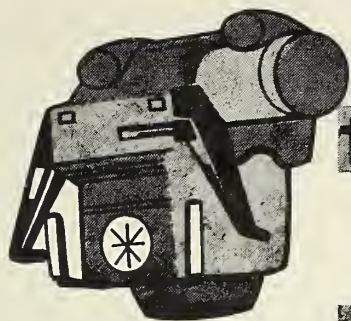
This patient is an eleven year old boy referred for evaluation of an irregular heart beat. He is otherwise asymptomatic and can keep up with his classmates in physical activities. His physical examination is normal except for the irregular heart beat. An EKG is taken and simultaneous leads V₁ and II rhythm strip is shown.



Questions

1. The simultaneous leads V₁ and II rhythm strip shows:
 - A. Sinus arrhythmia.
 - B. Second degree atrioventricular (AV) block type I or Wenckebach.
 - C. Junctional rhythm with exit block.
 - D. Atrial tachycardia with AV block.
 - E. All of the above.
2. The following statement(s) is/are true:
 - A. Congenital heart disease frequently coexists with congenital complete heart block.
 - B. Congestive heart failure in infants with heart block is uncommon unless there is some associated congenital heart lesion.
 - C. Congenital heart block is frequently associated with "corrected" or L-transposition of the great vessels.
 - D. AV Wenckebach phenomenon has been reported in trained athletes without evidence of heart disease.
 - E. All of the above.

(Continued on page 127)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Terrence C. Demos, M.D., a clinical associate professor of radiology at the Loyola University Medical Center in Maywood.

This 25 year old male had signs and symptoms of superior vena cava syndrome.



Figure 1—PA Chest

What is your diagnosis?

1. Retrosternal thyroid
2. Lymphoma
3. Thymoma
4. Teratoma
5. Chondrosarcoma

(Continued on page 124)

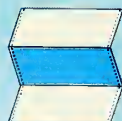
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Obituaries

***Benform, Myron Clyde**, Berwyn, died June 21, 1979, at the age of 73. Dr. Benform was a 1935 graduate of the University of Illinois.

****Bosselman, Beulah C.**, Evanston, died June 24, 1979, at the age of 82. Dr. Bosselman was a 1932 graduate of Rush-Pres.-St. Luke's Medical College.

***Coopersmith, Max Mordicai**, Chicago, died June 8, 1979, at the age of 82. Dr. Coopersmith was a 1926 graduate of the University of Illinois.

Federman, David, Los Angeles, formerly of Chicago, died at the age of 27. Dr. Federman was a 1976 graduate of the Loyola University Stritch School of Medicine.

***Feinerman, Albert H.**, Chicago, died recently at the age of 72.

****Greer, Mark**, Vandalia, died June 10, 1979, at the age of 90. Dr. Greer was a 1913 graduate of St. Louis University.

Gundersen, Gunnar, LaCrosse, Wisconsin, died recently. Dr. Gundersen was a 1920 graduate of Columbia University. He also founded the Gundersen Clinic-Lutheran Hospital complex in Wisconsin.

***Hinrichs, Marie Agnes**, Chicago, died May 11, 1979, at the age of 87. Dr. Hinrichs was a 1934 graduate of Rush Medical College. She also was former director of the Southern Illinois University-Carbondale health service.

***Johnson, Thomas A.**, Rockford, died December 1978, at the age of 52.

***Kohn, Ernest**, Springfield, died June 27, 1979, at the age of 64. Dr. Kohn was a 1940 graduate of University of Paccora, Italy.

****Lash, A. Lawrence**, Chicago, died May 19, 1979, at the age of 85. Dr. Lash was a 1918 graduate of Loyola University Stritch School of Medicine.

***Leckband, Norbert Frederick**, Arlington Heights, died July 5, 1979, at the age of 80.

Lombardo, Samuel S., Jacksonville, Florida, formerly of Chicago, died June 26, 1979.

****Maslow, Leo A.**, Lincolnwood, died June 10, 1979, at the age of 80. Dr. Maslow was a 1926 graduate of the University of Illinois.

Norgren, Carl H., Media, Pennsylvania, died June 14, 1979, at the age of 94.

Rubin, Simon, Merrillville, Indiana, formerly of Gary, died June 19, 1979, at the age of 70.

Torrey, Fran A., formerly of Pekin, died May 11, 1979, at the age of 62.

***Warren, Lewis T.**, Evanston, died June 27, 1979, at the age of 53. Dr. Warren was a 1952 graduate of the University of Michigan.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club

Clinics for Crippled Children Listed for September

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 24 general clinics, nine cardiac clinics and two clinics for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

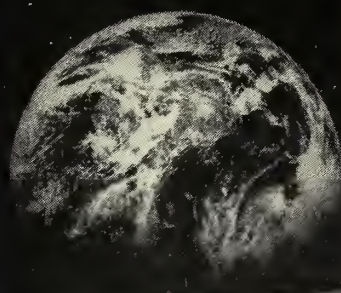
- Sept. 4 Park Ridge Cardiac—Lutheran Gen. Hosp.
- Sept. 5 Hinsdale—Hinsdale Sanitarium
- Sept. 5 Carmi—Carmi Township Hospital
- Sept. 6 Effingham—St. Anthony Mem. Hosp.
- Sept. 6 Lake County Cardiac—Victory Mem. Hospital
- Sept. 7 Division Cardiac—U. of I. at the Medical Center
- Sept. 10 Peoria Cardiac—St. Francis Hospital
- Sept. 11 East St. Louis—Christian Welfare Hosp.
- Sept. 11 Carrollton—Boyd Memorial Hospital
- Sept. 11 Peoria General—St. Francis Hospital
- Sept. 12 Chicago Heights Gen.—St. James Hosp.
- Sept. 12 Champaign-Urbana—McKinley Hosp.
- Sept. 12 Rock Island—Cerebral Palsy Foundation for Crippled Children and Adults
- Sept. 12 Joliet—St. Joseph's Hospital
- Sept. 13 Sterling—Community General Hospital
- Sept. 13 Springfield General—St. John's Hosp.
- Sept. 14 Chicago Heights Cardiac—St. James Hospital
- Sept. 17 Maywood—Loyola Medical Center
- Sept. 18 Belleville—St. Elizabeth's Hospital
- Sept. 18 Decatur—Decatur Memorial Hosp.
- Sept. 18 Rock Island Gen.—Moline Public Hosp.
- Sept. 19 Elgin—Sherman Hospital
- Sept. 19 Springfield Ped-Neuro—St. John's Hosp.
- Sept. 19 Centralia—St. Mary's Hospital
- Sept. 19 Evergreen Park—Little Company of Mary Hospital
- Sept. 20 Macomb—McDonough District Hospital
- Sept. 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Sept. 20 West Frankfort—Union Hospital
- Sept. 20 Rockford—Rockford Memorial Hospital
- Sept. 21 Kankakee Cardiac—St. Mary's Hosp.
- Sept. 24 Peoria Cardiac—St. Francis Hospital
- Sept. 25 Alton—Alton Memorial Hospital
- Sept. 25 Peoria General—St. Francis Hospital
- Sept. 26 Chicago Heights General—St. James Hospital
- Sept. 28 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting,

gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

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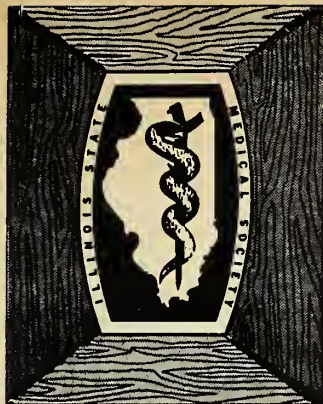
***Equivalent to penicillin V.**

Additional information available to the profession on request.



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I M J

Illinois Medical Journal

Vol. 156, No. 2, August, 1979

A Ten Year Follow-Up Of Lithium Use

BY PAUL C. HOLINGER, M.D. AND EDWARD A. WOLPERT, M.D., PH.D./CHICAGO

A follow-up of 74 patients treated with lithium carbonate by private psychiatrists over the past 10 years at a private hospital is presented. The patients were on lithium from one month to 10 years. Of these 74, 56 were diagnosed manic-depressive, 9 unipolar depressive, and 9 other psychoses. Fifty-one of the 74 (69%) responded positively to lithium in both the acute and long-term phase. Fifty-three patients (72%) suffered mild and/or severe recurrences; 24 of 74 (32%) suffered severe recurrences and 43 of 74 (58%) suffered mild recurrences. The average frequency of episodes decreased significantly for the total patient group and for each of the three diagnostic categories following lithium. Forty-eight of the 74 patients (65%) manifested side effects, with GI problems commonest; 7 patients (9%) had to permanently discontinue lithium due to side effects. Psychotherapy, relationships, and work tended to improve following institution of lithium in the 56 manic-depressives. The findings seem to indicate that results of lithium use by private psychiatrists in a private hospital are comparable to most other settings; that lithium protects less well against the mild recurrences of hypomania and mild depression than against the severe recurrences of mania and severe depression; that some recurrences might be prevented by keeping patients on lithium and increasing lithium doses when subtle signs of recurrence appear; and that more systematic studies of psychotherapy, relationship and work changes following lithium use are warranted.

Manic-depressive, or bipolar, illness is characterized by recurrences and remissions of mania (euphoria, pressure of speech, hyperactivity) and depression (depressed mood, physical sluggishness,

difficulty in thinking.) In 1949, Cade¹ reported that lithium seemed efficacious in treating disorders of the manic-depressive type and thereby introduced a new era of treatment and research. The effectiveness of lithium therapy in acute mania is now well known.¹⁻⁶ Regarding lithium's acute antidepressant effect, the majority of uncontrolled^{1,7-12} and controlled^{3,11,13-19} studies noted positive results, with a trend for bipolar illness to respond more often than unipolar (depression without mania) illness,¹⁷ but such findings need further confirmation. Lithium's acute effect in atypical affective syndromes and schizoaffective patients is also controversial.

Controlled²⁰⁻³³ and uncontrolled studies³⁴⁻⁸⁸ indicated that lithium has a prophylactic effect on mania (*i.e.*, prevents recurrences) in bipolar patients. Lithium is suggestive of prophylaxis for depression in bipolar and unipolar patients.^{17,20-33,39,40} Davis,⁴¹ statistically summarizing these investigations, concluded that methodologi-

PAUL C. HOLINGER, M.D., M.P.H., M. Div., is an associate attending physician affiliated with the department of psychiatry, Institute for Psychosomatic and Psychiatric Research and Training at Michael Reese Hospital and Medical Center in Chicago. Dr. Holinger, who recently completed a fellowship in psychiatric epidemiology at the Harvard University School of Public Health, was chief resident in the department of psychiatry at Michael Reese at this writing.

EDWARD A. WOLPERT, M.D., Ph.D., is the director of clinical services of the Michael Reese Hospital and Medical Center Institute for Psychosomatic and Psychiatric Research and Training. A board certified psychiatrist and psychoanalyst, Dr. Wolpert is also a clinical professor of psychiatry at the UC Pritzker School of Medicine. He serves as an associate editor for the International Journal of Psychoanalytic Psychotherapy and is a member of the faculty for the continuing education program for psychiatrists, Chicago Institute for Psychoanalysis.

**Preliminary results of this work were presented in Barcelona, Spain, at the Second World Congress of Biological Psychiatry, 1978, and appear in PROCEEDINGS OF THE SECOND WORLD CONGRESS OF BIOLOGICAL PSYCHIATRY (G. Ballus, Ed.), Elsevier, Amsterdam, 1979.*

Table 1
Recurrence Pattern By Type Of Recurrence And Diagnostic Category

Diagnostic Category	# of Patients In Diagnostic Category	# of Patients With Recurrences(%)*	# of Patients On Lithium At Time of Recurrence(%)*	# of Patients Needing Rehosp. for Recurrence(%)*	# of Patients On Lithium At Time of Rehosp. (%)*
Recurrences of Any Kind (Mania, Hypomania, Severe Depression, Mild Depression)					
Manic-Depressive	56	41 (73%)	25 (45%)	13 (23%)	5 (9%)
Unipolar Depression	9	7 (78%)	3 (33%)	3 (33%)	2 (22%)
Other Psychoses	9	5 (56%)	2 (22%)	4 (44%)	2 (22%)
Total	74	53 (72%)	30 (41%)	20 (27%)	9 (12%)
Severe Recurrences (Mania or Severe Depression)					
Manic-Depressive	56	16 (29%)	6 (11%)	9 (16%)	3 (5%)
Unipolar Depression	9	5 (56%)	2 (22%)	2 (22%)	1 (11%)
Other Psychoses	9	3 (33%)	0 (0%)	3 (33%)	0 (0%)
Total	74	24 (32%)	8 (11%)	14 (19%)	4 (5%)
Mild Recurrences (Hypomania or Mild Depression)					
Manic-Depressive	56	35 (63%)	23 (41%)	4 (7%)	2 (4%)
Unipolar Depression	9	4 (44%)	2 (22%)	1 (11%)	0 (0%)
Other Psychoses	9	4 (44%)	2 (22%)	3 (33%)	2 (22%)
Total	74	43 (58%)	27 (36%)	8 (11%)	4 (5%)

*(%) = % of Patients in Corresponding Diagnostic Category

cal considerations still warrant viewing the unipolar results with caution and suggested that lithium may exert its prophylactic antidepressant effects only on certain subgroups of unipolar and bipolar patients.^{17,40-42} The prophylactic effect of lithium for schizoaffective or atypical mania remains controversial.^{41,42}

Many side effects of lithium are documented.^{11,41,43-45} Uncomfortable and usually innocuous side effects can occur at therapeutic lithium blood levels (fine tremor, tiredness, weakness, dizziness, nausea, thirst). More serious side effects (vomiting, diarrhea, confusion, seizures, coma) may occur at excessive lithium blood levels. Chronic therapeutic doses may result in polyuria and polydipsia, nephrogenic diabetes insipidus, weight gain, edema, hypothyroidism and goiter.^{41,43,46-49} Rash and other skin changes, and electrocardiographic and hematologic abnormalities have been reported.⁴³⁻⁵⁰ Few reports, however, indicate the relative frequency of these various side effects.³⁷

Some reports have noted changes in the work and relationships of patients following institution of lithium.^{35,37,38,51-53} Work improvements have included greater reliability, productivity, and organizational capacity. Adverse effects included a curbed feeling, dampened creativity, and decreased productivity. Similarly, improvements in family and social relationships have included less erratic and destructive ways of relating and

greater sensitivity to others; adverse effects involved a decrease in the wit, charm, and engaging nature of certain patients. In addition, overall improvement of the patient may disrupt a lifelong family pattern of adapting to and using the illness.

Much psychoanalytic literature exists on the psychotherapy of manic-depressive illness,⁵⁴ but little is reported on the psychotherapy of lithium-treated patients. To many patients on lithium, psychotherapy is much less important.³⁷ Schou⁵⁵ noted many reasons that patients discontinue lithium and stressed the clinical importance of patient instruction and motivation. Benson⁵⁶ found that lithium combined with psychotherapy showed a markedly lower failure rate than found with lithium alone. Our earlier results³⁵ indicated that successful maintenance therapy with lithium made no difference in psychotherapy, which generally had been superficial both before and after lithium treatment.

In 1966, an open clinical study was begun at the Psychosomatic and Psychiatric Institute, Michael Reese Hospital, to test the effectiveness of lithium carbonate.^{35,38} This study differed from many investigations in that it was conducted within the setting of a psychiatric hospital treating mostly private, and fewer research, patients in a milieu emphasizing interpersonal and intrapsychic dynamics.⁵⁷ The evolution of this study has been described previously.^{35,38} The purpose of this paper is to report the 10 year follow-

Table 2
Average Frequency Of Episodes (Per Year)

		Manic Episodes No. Before Lithium	Depressed Episodes Before Lithium	Total Episodes Per Year Per Patient Before Lithium	Manic Episodes After Lithium	Depressed Episodes After Lithium	Total Episodes Per Year Per Patient After Lithium
Total Patients	74	1.46	2.50	3.95	.25***	.50***	.74***
Diagnostic Groups							
Manic-Depressive	56	1.76	2.25	3.99	.28***	.38***	.64***
Unipolar Depression	9	0.00	4.11	4.11	.00	1.69**	1.69**
Other Psychoses	9	1.05	2.44	3.50	.31	.07	.38*
"Chronic"	11+	1.36	1.26	2.62	.25++	.46	.71++

+ Patients include only those diagnosed as manic-depressive who have been on lithium five or more years, whose illness duration was five or more years, and who had at least one manic or depressive episode per year during the duration of their illness prior to lithium treatment.

* $p < .05$, matched t-test

++ $p < .015$, matched t-test

** $p < .01$, matched t-test

*** $p < .001$, matched t-test

up of patients on lithium in a private setting (Michael Reese Hospital), focusing on results of acute and prophylactic treatment with lithium, side effects, and changes in relationships, work and psychotherapy.

Methodology

Patients were diagnosed by the attending psychiatrists, and those without significant renal, cardiac, or neurologic disease were selected. Seventy-four patients were admitted consecutively to the study from 1966 through 1975. Details about institution of lithium and treatment exist in previous reports on this series of patients.^{35,38} Data for the current report are derived from inpatient records and follow-up questionnaires completed in 1968,³⁸ 1970,³⁵ and 1977 (the current report). A positive chronic therapeutic response was decrease in severity and/or number of affective episodes. "Episode" was used to describe extreme psychotic mood swings of mania, including both manic and hypomanic, and depression, including both severe depression, (incapacitating, manifesting dysphoric mood, anorexia, psychomotor retardation, insomnia, loss of self-esteem, slow thinking, anhedonia) and mild depression (not incapacity, yet more severe than normal sadness which is defined as an

ubiquitous, universal emotional response to everyday adaptation to stress, frustration, and loss). "Recurrence" describes episodes occurring after lithium institution.

Of the 74 patients included in the study, 46 were female and 28 were male. Fifty-six were diagnosed manic-depressive (mean age of onset of illness was 29.7 years), 9 unipolar depressive (mean age of onset of illness was 27.1 years), and 9 "other psychoses" (all 9 were diagnosed schizoaffective schizophrenia; mean age of onset of illness was 22.8 years). At the conclusion of the current data collection in the 74 patients, 27 patients had been on lithium from 1 month to 11 months, 20 from 12 months to 3 years 11 months, 17 from 4 years to 6 years 11 months, and 10 from 7 years through 10 years.

Results

I. Response (acute and long-term). Fifty-one of the total 74 patients (69%) responded positively to lithium in the acute phase, and 51 of 74 (69%) had a long-term positive response. Forty-six of the 56 manic-depressive patients (82%) responded positively to lithium during the acute episode, and 48 responded positively long-term (86%). Two of the 9 unipolar depressed patients responded positively in the acute phase, and 1 re-

Table 3
Side Effects*

Diagnostic Category	# Of Patients In Diagnostic Category	# Of Patients With Any Side Effects	GI (Nausea, Vomiting, Diarrhea)	Tremor	CNS (Confusion, Lethargy, Tiredness)	Thirst & Polyuria	Hypo-Thyroidism	Ataxia
Total Population	74	48 (65%)	32 (43%)	22 (30%)	18 (24%)	8 (11%)	3 (4%)	6 (8%)
Manic-Depressives	56	35 (64%)	24 (43%)	17 (30%)	13 (23%)	6 (13%)	3 (5%)	6 (11%)
Unipolar Depression	9	7 (78%)	6 (67%)	2 (22%)	3 (33%)	1 (11%)	0 (0%)	0 (0%)
Other Psychoses	9	5 (55%)	2 (22%)	3 (33%)	2 (22%)	1 (11%)	0 (0%)	0 (0%)

* (%) = % of Patients Within the Diagnostic Category with the Particular Side Effect

sponded positively long-term. Three of 9 patients with "other psychoses" responded positively during the acute phase and 2 of 9 responded positively long-term.

II. Recurrences (Tables 1 and 2). Of the 74 patients, 53 (72%) suffered a recurrence of some kind, *i.e.*, mania, hypomania, severe or mild depression, and 30 (41%) of those with recurrences were on lithium at the time of the recurrence. Table 1 summarizes the recurrence pattern by type of recurrence and diagnostic category. Patients frequently suffered more than one type of recurrence. Also studied were the mean number of manic, depressed, and total episodes before and after the institution of lithium (Table 2). For the total patient group of 74 there was a shift from an average of nearly 4 episodes per year to less than 1 episode per year after lithium institution.

In an attempt to address the "before-and-after" methodological issue, 11 patients were studied who had been on lithium 5 or more years, whose illness duration prior to lithium was 5 or more years, and who had at least 1 manic or

depressive episode per year during the duration of their illness prior to lithium treatment (Table 2). Prior to lithium treatment these patients suffered an average of one episode about every 4½ months; with lithium, they averaged 1 recurrence about every 17 months.

III. Side Effects (Table 3). The frequency of specific side effects is summarized in Table 3. Sixty-five percent had some side effects during the course of their treatment which were attributed to lithium. Seven patients (9% of total) had to permanently discontinue lithium due to side effects.

IV. Psychotherapy (Table 4a). Of those patients on lithium who seemed to their psychiatrist to demonstrate a change in how they used psychotherapy, 24 showed an improvement in psychotherapy. Of those 24, in 15 the psychotherapy assumed a more analytic insight-oriented model, and in 9 it became more supportive; 22 of those 24 patients were judged to have responded positively over-all to lithium in the acute phase, and 23 responded positively long-term. In the 3 pa-

Table 4A
Psychotherapy After Lithium*

Diagnostic Category	No. of Patients	Improvement	No Change	Worse	Data Not Available
All Patients	74	24 (32%)	26 (35%)	3 (4%)	21 (28%)
Manic-Depressive	56	22 (39%)	18 (32%)	3 (5%)	13 (23%)
Unipolar Depression	9	0 (0%)	6 (67%)	0 (0%)	3 (33%)
Other Psychoses	9	2 (22%)	2 (22%)	0 (0%)	5 (56%)

Table 4B
Changes In Relationships With Family And Friends After Lithium*

Diagnostic Category	No. of Patients	Improvement	No Change	Worse
All Patients	74	37 (50%)	37 (50%)	0 (0%)
Manic-Depressive	56	34 (61%)	22 (39%)	0 (0%)
Unipolar Depression	9	2 (22%)	7 (78%)	0 (0%)
Other Psychoses	9	1 (11%)	8 (89%)	0 (0%)

Table 4C
Work Changes After Lithium*

Diagnostic Category	No. of Patients	Improvement	No Change	Worse
All Patients	74	35 (47%)	38 (51%)	1 (1%)
Manic-Depressive	56	33 (59%)	22 (39%)	1 (2%)
Unipolar Depression	9	1 (11%)	8 (89%)	0 (0%)
Other Psychoses	9	1 (11%)	8 (89%)	0 (0%)

* (%) = % of Patients in Corresponding Diagnostic Category

tients in whom psychotherapy "worsened" following lithium, the therapy was thought to become more supportive; the 3 responded positively to lithium both acutely and long-term.

V. Relationships (Table 4b). No patient became worse in terms of their relationships, and half improved. Patients whose relationships had improved were most often characterized by their attending physicians as being less impulsive, less erratic, less fragile, and more confident in those relationships. A comparison between the 56 manic-depressive patients and the other 18 patients in terms of "improvement" versus "no change" and "worse" revealed that the manic-depressive group had significantly greater improvement in relationships after lithium than the other patients ($p < .01$, χ^2).

VI. Work (Table 4c). Nearly half the total population showed work improvement with lithium. Of those, many noted to their therapists a decrease in creativity and inspiration, although work was assessed as improved, and several noted an increase in creativity and capacity to organize. A comparison between the 56 manic-depressive patients and the other 18 patients in terms of "improvement" versus "no change" and "worse"

revealed the manic-depressive group had significantly greater improvement in work after lithium than the other patients ($p < .01$, χ^2).

Discussion

The 10 years' accumulated experience by a group of predominantly private therapists is of interest to the practitioner as well as to the researcher in providing a sense of what might generally be expected in the usual treatment of manic-depressive illness with lithium. The results must be viewed cautiously, however, due to the open nature of the study with its attendant methodological problems.^{22,58,59}

Eighty-two percent improvement of manic-depressive patients in either acute phase with lithium treatment is a highly satisfactory therapeutic response and is in general agreement with previous studies.^{37,60} While comparisons of improvement between studies should be made with caution because different evaluative criteria are used,⁶ therapists should expect a generally favorable result in most correctly diagnosed cases.

A majority of patients in the study (72%) suffered from recurrences, more mild than severe. However, many patients (32%) had episodes of mania or severe depression, or both

and adequate treatment of those episodes frequently required hospitalization. Recurrences of either the mild or severe type were almost invariably treated successfully, and lithium was nearly always continued or increased during the treatment of a recurrence.

One explanation of the recurrence data is that lithium tends to protect less well against the milder recurrences than against severe recurrences. Such an hypothesis is suggested by the fact that more patients were on lithium at the time of mild recurrences than were on lithium during severe recurrences. Another possibility is that mild recurrences represent a failure of the therapist to be sensitively in tune with his patient and increase the lithium dose when needed. Finally, mild recurrences may represent characterologic manifestations distinct from manic-depressive psychosis. Although a majority of patients in the study suffered recurrences and nearly a third of all patients need rehospitalization, lithium was shown to have a positive effect by the significant decrease in affective episodes per year (Table 2). Studies employing the before-and-after approach have been criticized particularly because they were not carried out blindly and make assumptions about the course of the illness which are not entirely accepted, *i.e.*, that recurrences of episodes will occur as frequently in the future as they did in the past.^{22,58,59} Studying the group (Table 2) of chronic patients was an attempt to minimize the possibility that a decrease in the number of episodes was due to the course of the disease itself rather than to the effectiveness of lithium treatment. In this group, also, lithium was effective in decreasing the average frequency of episodes.

Sixty-five percent of the patients had side effects. The commonest involved the GI system and were minor. However, 24% had CNS symptoms of some seriousness, and there were three cases of hypothyroidism. Lithium cannot, therefore, be seen as an innocuous medication. In addition, 9% of the patients in the study discontinued lithium permanently due to side effects attributed to lithium. It may be that while the private psychiatrists were acutely observant of side effects in their patients, they did not have enough experience with lithium to adjust dosage amount in order to prevent discontinuation of lithium use.^{61,62}

In psychotherapy, work, and relationships, the manic-depressive patients, as compared to the other diagnostic categories studied, appeared to benefit most from lithium use. The current re-

sults, differing from our earlier work,³⁵ suggest that many manic-depressive patients can use psychotherapy more effectively once on lithium, and that for the majority of those who do, psychotherapy becomes more insight-oriented and analytic rather than merely supportive. The results indicating improvement in work and relationships of patients treated with lithium appear consistent in general with most published reports, both with respect to the improvement *per se* as well as the qualitative aspects of the changes as reported by the private physicians. ◀

Acknowledgement

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References

A complete list of references for "A Ten Year Follow-Up Of Lithium Use," may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

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Renal Infection Stones

By ANTHONY J. SCHAEFFER, M.D./Chicago

The role of bacteria in the etiology of recurrent kidney stones has not been fully appreciated. Urinary infection with a urea-splitting organism may, if inappropriately treated, lead to formation of an infection stone. The bacteria harbored within the stone are not amenable to antimicrobial therapy; with persistent infection the stone enlarges and causes considerable morbidity and loss of renal parenchyma. The two cases discussed outline the diagnostic and therapeutic modalities required for successful management.

The association of urinary tract infection with renal stones is well recognized¹⁻³ but the role of bacteria in the etiology of recurrent calculi has not been fully appreciated.^{4,5} Nevertheless, renal infection stones are one of the most serious complications of unresolved or recurrent bacteriuria. Although management of this complicated problem requires a specialist, the diagnosis can frequently be made by a physician who appreciates the interrelationship between these entities.

The rapidity of formation and morbidity associated with infection stones and the surgical and biochemical techniques utilized to treat them are illustrated by the following cases.

Case Reports

A 34-year-old white female had an episode of bilateral pyelonephritis in 1965 and again in 1976, when a urine culture showed *Escherichia coli*. Intravenous urogram showed bilateral nephrocalcinosis and no renal pelvic calculus. Cystogram and cystoscopy were unremarkable. She was placed on a low calcium diet and was well until December of 1976, when she presented with left flank pain, fever and chills. Urine culture



Figure 1
Preliminary film demonstrates bilateral nephrocalcinosis and left renal pelvic stone.

showed *Proteus mirabilis*, 70,000 colony-forming units per ml. Intravenous urogram showed bilateral nephrocalcinosis and a 1 × 2cm calculus in the left renal pelvis (Fig. 1). The serum creatinine was 1.4mg% and the 24 hour excretion of calcium was slightly elevated (approximately 250mg per 24 hours on 3 occasions). The remainder of the metabolic evaluation for renal stone disease was unremarkable.

Following an adequate response to gentamycin therapy the patient underwent a coagulum

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Figure 2

Plain film tomogram illustrates a large staghorn calculus and multiple upper and lower calyceal calculi.



Figure 3

Renal angiography showing pyelocaliectasis and cortical atrophy of the upper half of the kidney.

pyelolithotomy. In addition to the large pelvic stone, multiple small fragments were embedded in the coagulum. Although pelvic urine and superficial stone cultures showed no growth, the crushed stone cultures disclosed 600 colonies of *P. mirabilis*. The stone was composed of struvite 83%, apatite 12% and whewellite 5%.

The patient was maintained on nalidixic acid therapy for 1 month and cultures 4 months post-operative showed no growth. Diuretic therapy was instituted to control the idiopathic hypercalcuria.

Comment: A struvite-apatite stone can develop rapidly (<6 months) following infection with a urea-splitting organism. Fortunately, pre-existing intrarenal calculi were not secondarily infected.

Second Case: A 39-year-old black female presented with renal failure, intractable urine infection, and a history of a left nephrectomy (for an

infected staghorn calculus) 12 years prior to admission. The serum creatinine was 10.5mg%, and the creatinine clearance was 3ml per minute. The catheterized urine specimen showed 2 strains of *E. coli* greater than 100,000 colonies per ml. Plain film tomograms disclosed a large staghorn calculus and multiple upper and lower calyceal calculi (Fig. 2). An arteriogram showed a solitary right kidney with pyelocaliectasis and atrophy of the cortex of the upper half of the kidney (Fig. 3). Other causes of renal calculi were excluded by appropriate laboratory studies. Following hemodialysis and while on ampicillin therapy, all intraoperatively radiographically identifiable stones were removed through a pyelolithotomy and upper and lower pole nephrotomies. Aspirated pelvic urine and stone surface cultures showed rare *E. coli*; crushed stone cultures demonstrated rare *P. mirabilis* and *E. coli*. Stone analysis indicated struvite 82% and apatite

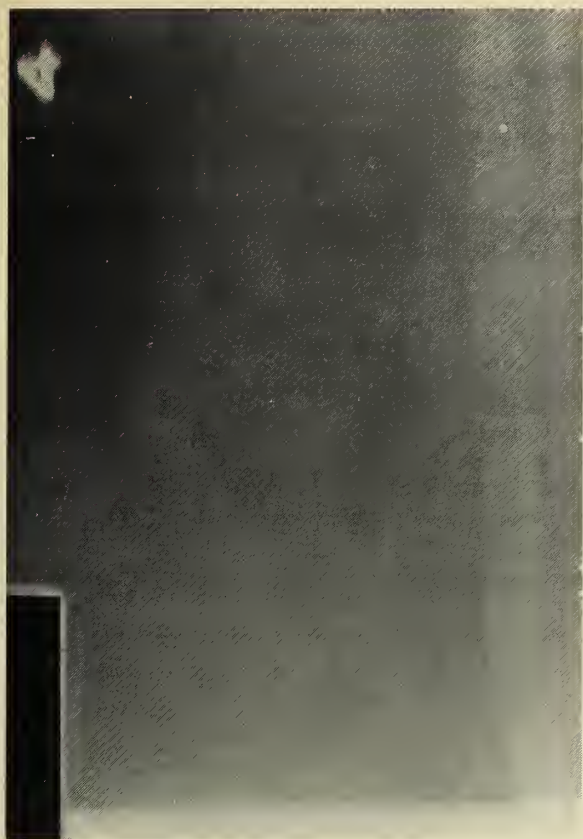


Figure 4
No calculi are identifiable on postoperative plain film tomograms.



Figure 5
Nephrostogram demonstrates integrity of collecting system.

18%. Postoperative plain film tomograms showed no calculi (Fig. 4). Irrigation of the collecting system with 10% hemiacidrin through a nephrostomy tube (Fig. 5) was performed for two days after the integrity of the collecting system and sterility of the urine were assured. The nephrostomy tube was removed and the patient maintained on penicillin for three months. Six months postoperatively, the serum creatinine was 3 mg%, the creatinine clearance was 27 ml/minute and the urine was sterile off therapy.

Comment: Return of adequate renal function, in a patient severely compromised by infection stones, was accomplished by surgical removal of the calculi which harbored both urea and non-urea-splitting bacteria.

Discussion

The majority of urinary pathogens are incapable of producing infection stones because

they lack the enzyme urease. *Proteus* species, *Klebsiella*, and occasionally *Pseudomonas* and staphylococci have this enzyme, which alkalizes urine by hydrolysing urea to ammonia. This leads to supersaturation, decrease in solubility of magnesium and calcium phosphate and formation of stones composed of struvite ($\text{MgNH}_4\text{PO}_4 \cdot 6\text{H}_2\text{O}$) and apatite ($\text{Ca}_{10}(\text{PO}_4)_6(\text{OH})_2$).⁶

The infection which ultimately leads to a kidney stone commonly begins inconspicuously as an inadequately treated cystitis. Patients with indwelling catheters, bacterial prostatitis and urinary conduit diversion are also particularly susceptible. After infecting the renal pelvis, urea splitting organisms begin to foster conditions favorable for stone growth. The bacteria become entrapped within the crystals where they are inaccessible to antimicrobial agents. Using culture techniques which distinguish surface contamination from bacteria actually residing within the

stone, a simple organism, usually *P. mirabilis*, was recovered from two-thirds of struvite stones; in one third, *P. mirabilis* was accompanied by other organisms.⁵ The length of time required to produce a stone is subject to many variables; large pelvic stones, however, have occurred within six months.

Although the urine may be sterilized while the patient is on antibiotic therapy, bacteriuria rapidly recurs following cessation of therapy, and is virtually diagnostic of bacterial persistence inside struvite calcifications. One-third of affected patients present with *only* lower urinary tract symptoms, while two-thirds complain of flank discomfort, chills, and fever. Because these stones are relatively radiolucent, plain film tomograms *must* be obtained to adequately define the number, size and position of calculi. Appropriate studies should also be obtained to investigate other causes of renal stones.

Non-struvite stones may become secondarily infected and, conversely, other abnormalities in the urinary tract may harbor bacteria in the presence of a sterile stone. Therefore bacterial localization studies utilizing ureteral catheters should be performed if there is any question as to the etiology of bacterial persistence.

Medical management (continued suppressive antimicrobial therapy and acidification) will temporarily relieve symptoms and prevent or retard deterioration of renal function in some patients. Small struvite stones may dissolve, but the majority will persist or enlarge.⁷ The urease inhibitor acetohydroxamic acid, although capable of dissolving struvite and apatite crystals *in vitro*, has not been effective clinically.⁸ Large infection stones (e.g., staghorn calculi) very frequently are symptomatic (flank pain and hematuria), and lead to deterioration of renal function and nephrectomy.⁹ Blandy reported a 28% mortality rate with conservative management of staghorn calculi.¹⁰

Surgical management, which is required for the majority of infection stones, must include preoperative sterilization of the urine and removal of all radiographically demonstrable calculi through a pyelotomy and/or nephrotomy. When an infection stone is small, its total removal is easily accomplished. Large branched calculi which extend into infundibula and calyces are often friable and soft. Despite copious irrigation at the time of surgery small fragments may be left behind. Postoperative radiographs have demonstrated calculi in 36-45% of patients following infection stone surgery.^{4,11,12} Almost certainly,

fragments which are not radiographically discernable but which harbor bacteria are more often left behind.

Postoperative Irrigation

For those selected cases in which fragments are demonstrable, or in our opinion probable, we utilize postoperative irrigation. The patient is maintained on appropriate antimicrobial therapy (usually penicillin G) and daily aspiration of urine from the nephrostomy tube for culture is performed to ensure sterility. When the integrity of the collecting system has been confirmed by nephrostogram, irrigation is begun with normal saline with the bottle at the lowest height possible to permit flow of 100cc/hr. An outflow tube is connected to the nephrostomy catheter so that the patient or nurse can easily stop the flow of fluid and provide dependent drainage if any pain, fever or discomfort occurs. If no difficulties are encountered, irrigation with 10% hemiacidrin is started. In addition to several multivalent organic acids buffered to pH 3.7, it contains 639 ± 42 mEq/liter magnesium. Action is probably due to an ion exchange in which the calcium of the stone is replaced with magnesium to form the equivalent magnesium salt which is soluble in the gluconocitrate solution.⁴ In the absence of radiographically visible particles, hemiacidrin irrigation is discontinued after 24-48 hrs. Otherwise, irrigation is continued until plain film tomograms demonstrate complete dissolution. Occasionally a patient may require a bladder catheter to prevent vesical irritation.

Despite its effectiveness this drug is *not* currently approved by the Federal Drug Administration for use in the renal pelvis. Approval was withdrawn following report of four deaths in patients who had apparent urine infections and/or septic episodes during irrigation. If this drug is to be used for postoperative irrigation, strict adherence to the following rules must be observed. 1) Daily cultures of urine aspirated from the nephrostomy tube must be sterile. 2) There must be no evidence of fever or flank pain. (At the first sign of discomfort, the patient is instructed to disconnect the inflow of hemiacidrin.) 3) Daily magnesium levels must be determined. With these precautions, postoperative irrigation has been safely and effectively employed for up to 30 days.^{4,13}

Because re-infection of the urine with urea splitting organisms is possible in patients susceptible to recurrent infection, close postoperative

bacteriologic follow up is mandatory. With female patients, antimicrobial therapy may be stopped two to four weeks after surgery and frequent follow-up cultures obtained. Men who have chronic bacterial prostatitis and patients with permanent catheter drainage or other forms of diversion will require frequent cultures and intermittent or continuous antimicrobial therapy to keep the urine free of urea splitting organisms. Utilizing the bacteriologic, surgical, and biochemical techniques outlined above, patients with infection stones can be relieved of considerable morbidity and the associated loss of renal function uniformly associated with infection stones. ◀

References

1. Hellstrom, J.: "The Significance of Staphylococci in the Development and Treatment of Renal and Ureteral Stones," *Brit. J. Urol.* 10:348-372, 1938.
2. Jennis, F., Levan, J.M., Neale, F.C. and Posen, S.: "Staghorn Calculi of the Kidney: Clinical, Bacteriological, and Biochemical Features," *Brit. J. Urol.* 42:511-518, 1970.
3. Chute, R. and Suby, H.I.: "Prevalence and Importance of Urea-Splitting Bacterial Infections of the Urinary Tract in the Formation of Calculi," *J. Urol.* 44:590-595, 1940.
4. Nemoy, N.J. and Stamey, T.A.: "Surgical, Bacteriological, and Biochemical Management of 'Infection stones'," *JAMA* 215:1470-1476, 1971.
5. Thompson, R.B. and Stamey, T.A.: "Bacteriology of Infected Stones," *Urology* 2:627-633, 1973.
6. Griffith, D.P., Musher, D.M. and Itin, C.: "Urease, The Primary Cause of Infection-Induced Urinary Stones," *Invest. Urol.* 13:346-350, 1976.
7. Chinn, R.H., Maskell, R., Mead, J.A. and Polak, A.: "Renal Stones and Urinary Infection: A Study of Antibiotic Treatment," *Brit. Med. J.* 2:1411-1413, 1976.
8. Griffith, D.P., Bragin, S. and Musher, D.M.: "Dissolution of Struvite Urinary Stones, Experimental Studies in Vitro," *Invest. Urol.* 13:351-353, 1976.
9. Singh, M., Chapman, R., Tresidder, G.C. and Blandy, J.: "The Fate of the Unoperated Staghorn Calculus," *Brit. J. Urol.* 45:581-585, 1973.
10. Blandy, J.P. and Singh, M.: "The Case for a More Aggressive Approach to Staghorn Stones," *J. Urol.* 115:505-506, 1976.
11. Barney, J.D.: "The Question of Recurrent Renal Calculi," *Surg. Gynec. Obstet.* 35:743-748, 1922.
12. Comarr, A.E., Kawaichi, G.K. and Bors, E.: "Renal Calculosis of Patient With Traumatic Cord Lesions," *J. Urol.* 87:647-656, 1962.
13. Jacobs, S.C. and Gittes, R.F.: "Dissolution of Residual Renal Calculi With Hemiacidrin," *J. Urol.* 115:2-4, 1976.

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Case Report

Mesenteric Cyst Causing Partial Intestinal Obstruction

By B. AGARWALA, M.D., L. THACHENKARY, M.D., G. LONDON, M.D.,
T. BAFFES, M.D., and H. LEVY, M.D./Chicago

This paper reports a rare case of mesenteric cyst causing partial intestinal obstruction. A three-year-old girl presented with history of intermittent vomiting. Physical examination was not suggestive of the diagnosis, which was made on laparotomy. This is a rare entity and must be considered in differential diagnosis of patients with partial or complete intestinal obstruction with or without a palpable abdominal mass. Etiology, pathology, clinical manifestations and management of the mesenteric cyst are discussed.

Cystic lesions of the mesentery are very uncommon. The first reported case of a mesenteric cyst was observed during necropsy by Benevieni, a Florentine anatomist in 1507.¹ In 1842, Rokitsky, published the first accurate description of a chylous cyst at necropsy.² In 1960, Sprague

reported incidence in the Los Angeles area to be one per 100,000 hospital admissions.³ Barr, *et al.*, pointed out in their 1964 publication that the preoperative diagnosis is very rarely made because the lesion is not usually considered in the differential diagnosis.⁴ Although rare, incidence

of the mesenteric cyst is frequent enough to be seen by most general surgeons from time to time.

Our purpose is to report a case of mesenteric cyst in a three-year-old girl who presented with symptoms of intermittent partial obstruction of the small intestine. This is the first case in five years seen in our medical center.

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History

A three-year-old black female was admitted with abdominal pain and vomiting of two days' duration. She had vomited five times each day and the vomitus was clear in color. Parents denied any history of fever or diarrhea. The pain was mild and localized in the upper abdomen. There was no relation of these symptoms to ingestion of food. She had experienced similar symptoms intermittently for the past four months. However, the symptoms previously resolved spontaneously and were never severe enough to seek emergency medical care. Her past and family histories were unremarkable.

On physical examination she appeared to be a well-developed, well-hydrated asthenic young girl in no acute distress. Her vital signs were

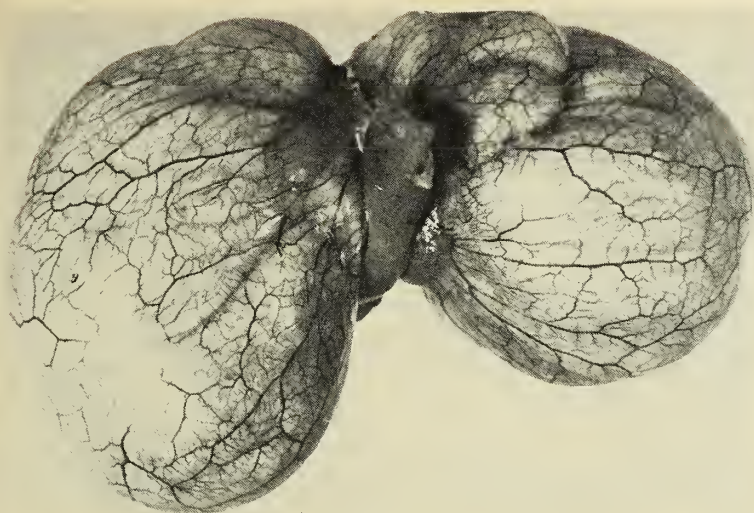


Figure 1

Gross photograph of Dumbbell-shaped cyst arising from the mesentery of the jejunum.

as follows: temperature 36° centigrade; heart rate 96/minute; respiratory rate 22/minute; B.P. 100/70 mm.Hg; height 90 cm.; and weight 15 kilograms. Abdominal examination revealed a soft, non-tender scaphoid abdomen without evidence of masses or organomegaly. Rectal examination and the remainder of physical examination were normal.

Laboratory

The following laboratory tests were normal: complete blood count, urinalysis, electrolytes, BUN, creatinine, blood lead level and liver enzymes.

Lower gastrointestinal contrast study was normal. The upper gastrointestinal contrast study ruled out any obstruction in the esophagus or stomach. However, a follow-through small bowel contrast study revealed evidence of a partial obstruction in the proximal jejunal loop. A 24 hour follow-up film showed very little contrast material in the ascending colon. Most of the contrast material was still seen in the proximal small bowel.

Hospital Course

The patient was treated conservatively with intravenous fluid therapy. Although her abdomen remained soft with hyperactive bowel sounds, protracted vomiting continued. She underwent laparotomy because the upper gastrointestinal contrast study revealed some form of obstruction in the high intestine. At surgery a mildly

dilated proximal portion of the jejunum was noted. A large bilobed yellow cystic mass was attached to the mesenteric border of jejunum distal to the dilatation causing obstruction to the intestinal lumen. Partial volvulus of the proximal jejunum was also noted. The cystic mass and 4 cm. of the jejunum were resected with end-to-end jejunal anastomosis. Postoperative course was uneventful. She tolerated her regular

diet well before she was discharged from the hospital.

The excised specimen was a loop of jejunum, 4cm. and patent throughout, with a dumbbell shaped cyst (Fig. 1) protruding from each side of the mesentery. One cyst measured 7×4cm. and the other measured 5×4cm. The cystic cavities contained 200ml. of milky fluid. The cystic wall was thin, measuring 0.1cm. in thickness except at the mesenteric attachment where it measured 0.3cm. There was no communication between the lumen of the intestine and the cystic cavities.

Microscopically, the cyst wall was made up of fibrocollagenous tissue and a few strands of muscle fibers lined by flattened mesothelium (Fig. 2). At the mesenteric attachment of the cyst, the muscular layer was thick and composed of inner circular and outer longitudinal layers with ganglion cells, which seemed to be branching off from the intact intestinal wall. These findings are consistent with mesenteric cyst and suggest its origin from a partial duplication of intestine.

Discussion

Opinion varies regarding etiology of the cysts. This is probably due to their rarity and a resulting lack of information. Ford, in 1960, summarized the various proposed theories by different authors.⁵ Bearhs, *et al.*, believed that the cysts are preformed and developmental anomalies, possi-

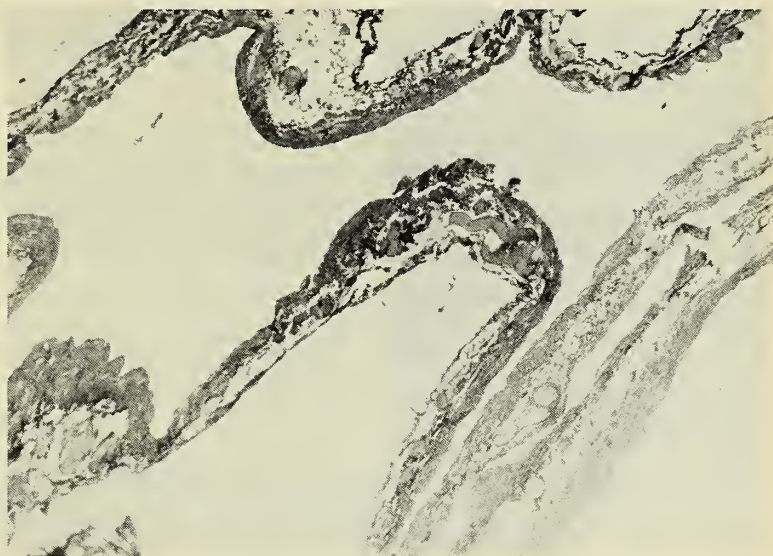


Figure 2

Microscopic photograph of the cyst wall.

bly traumatic in a few cases and occasionally from degeneration of lymph nodes. Because of extensive anastomosis of the lymphatic ducts, they could not produce the cyst from mechanical obstruction of the thoracic duct in experimental animals.⁶ Most observers agreed that the cysts arise from the continued growth of the congenitally malformed or malpositioned lymphatic tissues.^{7,8}

Vaughn, *et al.*, reported a 2:1 female to male incidence ratio.⁹ More recently, Sanchez *et al.*, did not show any sex predilection.¹⁰ There was no definite predilection for race, but some reports suggest low incidence in blacks. Burnett, *et al.*, in a 200-case review of the literature, noted that only 25% occurred before 10 years of age and 5.5% presented under a year of age.¹¹

Clinical manifestation may range from asymptomatic to extremely sick patients. Many reported cases were discovered during laparotomy undertaken for some other reason. Large abdominal masses may cause acute abdominal pain from intestinal obstruction. Rupture and hemorrhage

within the cyst can occur from trauma or spontaneously. Both complete and partial obstruction can develop from external pressure on the intestinal wall by the mass. Stovicek, *et al.*, reported a significant number of cases presented with malabsorption syndrome from diarrhea associated with partial bowel obstruction.¹² Ford reported a case in 1960 presenting with rectal bleeding from large bowel obstruction. Rectal bleeding was secondary to passive congestion of the hemorrhoidal veins.⁵ Dysuria and frequency may result from pressure over the urinary bladder.

Diagnostic Aids

When an intraabdominal mass is palpable, a plane roentgenography of the abdomen may suggest a soft tissue density. However, when the cyst is small it may not be diagnostically helpful. Upper and lower bowel contrast study may suggest a partial or complete obstruction or displacement of the adjacent structures. At the present time ultrasound and computerized axial tomography (CAT) scanning will be of tremendous help.

Intravenous pyelography is not of diagnostic help and aortic angiography is not indicated.

Differential diagnosis could involve numerous pathologic entities. When the cystic mass is palpable, it must be differentiated from other cysts of omental, ovarian and renal origin. The possibility of an intestinal duplication must be considered. Warfield suggested that a soft, rounded, smooth, nontender and very mobile abdominal mass, especially in transverse direction, should raise the possibility of a mesenteric cyst.¹³

All mesenteric cysts must be removed surgically. When noted on laparotomy for some other reason, it must be removed in total to avoid complications, *e.g.*, rupture, hemorrhage, intestinal obstruction and obstructive uropathy. ◀

References

A complete list of references for "Mesenteric Cyst Causing Partial Intestinal Obstruction," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Case Report

Bronchogenic Carcinoma in a Patient with Hodgkin's Disease

BY PUTHALATH K. RAGHUPRASAD, M.B.B.S., M.R.C.P. (U.K.), JULIO C. ARROYO, M.D.,
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Second neoplasms in patients with Hodgkin's Disease are being reported with increasing frequency, especially since the introduction of multimodality therapy with combined radiotherapy and chemotherapy. Although acute myelogenous leukemia has been the most frequent second neoplasm, a variety of solid tumors have also been noted. Bronchogenic carcinoma, however, has been reported with surprisingly low frequency.

We report a 38-year-old male patient with previously treated Hodgkin's Disease who died of disseminated bronchogenic carcinoma. His clinical presentation was strongly suggestive of recurrent Hodgkin's Disease and was interpreted as such. We suggest that bronchogenic carcinoma be considered in the differential diagnosis of recurrent Hodgkin's Disease whenever pulmonary involvement is present, or when the clinical presentation is atypical.

The occurrence of second malignancies in patients with Hodgkin's Disease is a well recognized problem. An incidence of such second primary malignancies of 1.6% and 2.2% has been noted in two separate series.^{1,2} The increased incidence of second primaries in patients with Hodgkin's Disease compared to the non-neoplastic population has been estimated at 14.4 times for any neoplasm,³ and 2-6 times for the carcinomas.⁴ The

most common secondary neoplasms seen in patients with Hodgkin's Disease have been the leukemias, particularly Acute Myeloid Leukemia^{5,6} and carcinoma of the skin.⁴ Bronchogenic carcinoma has been reported infrequently in patients with Hodgkin's Disease, despite the frequency of this tumor in the general population.^{2,3,7} We report our experience with a patient who had metastatic bronchogenic carcinoma undiagnosed during life and

which was interpreted as recurrent Hodgkin's Disease.

Case Report

A 29-year-old white male developed left posterior cervical adenopathy early in 1968. He was diagnosed as having Hodgkin's Disease on node biopsy and was treated by radiation therapy as follows: 4150 rads of tumor dose to left supraclavicular mass, 4120 rads of tumor dose to right cervical nodes, 3030-3800 rads of tumor dose to mediastinal nodes. This resulted in complete remission. In late 1972, he was readmitted with recurrent disease, this time with hepatosplenomegaly. He was treated with combination chemotherapy consisting of Nitrogen Mustard, Vincristine, Procarbazine and Prednisone (MOPP) starting late in 1972 and continuing for one year. He received six cycles. A complete remission was obtained.

In January, 1977, he was readmitted because of weakness, weight loss, fever and jaundice. Physical examination revealed hepatosplenomegaly. A liver scan revealed areas of decreased uptake (Figure 1).

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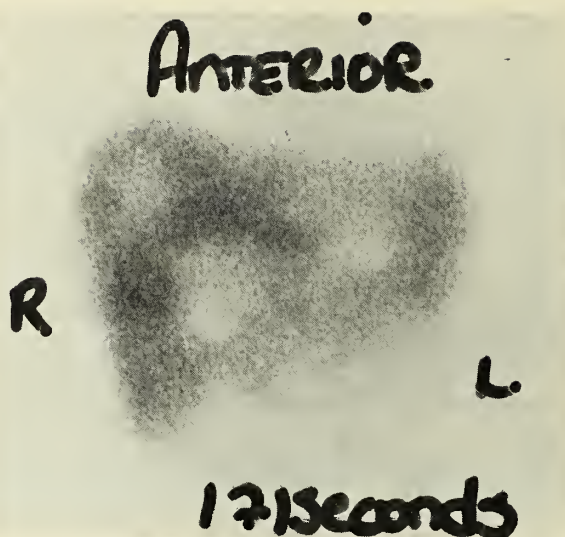
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Figure 1
99 mTc liver scan
in February, 1977,
showing multiple
large areas of de-
creased uptake.
Liver biopsy
showed Hodgkin's
Disease.



Alpha-fetoprotein was negative but CEA was 72 mg/ml. A needle biopsy of the liver one month later, showed pleomorphic elements with a few cells highly suggestive of Reed-Sternberg cells. He was restarted on MOPP and received five cycles. His symptoms showed improvement. However, five months later and one month before his death, while still on MOPP, he was readmitted with pleuritic chest pain, productive cough and moderate dyspnea. Examination revealed diminished breath sounds and a pleural friction rub in the middle and lower lung fields bilaterally. Radiographs of the chest revealed bilateral parenchymal infiltrates and pulmonary function tests showed combined obstructive and restrictive defects. A search for viral, bacterial, and fungal organisms was unrevealing. Before a successful conclusion of the investigations, the patient left the hospital against medical recommendation.

The final admission was precipitated by worsening dyspnea and pain in the left buttock and thigh. On examination there was hepatosplenomegaly, but no enlarged nodes. The pleural friction rub had disappeared. Neurological examination revealed no peripheral nerve dysfunction. A chest roentgenogram showed more extensive pul-

monary infiltrates with questionable cavitation (Figure 2). Arterial blood gas determination revealed marked hypoxemia with a mild respiratory alkalosis. His Hemogram showed Hemoglobin of 8.6g%, Hematocrit of 27.8%, WBC 12,700, Polymorphs 82, Bands 9, Lymphocytes 9, and Monocytes 11. Platelets were 154,000/mm³. Liver profile showed total bilirubin

1.5mg, direct bilirubin 1.0mg, SGOT 65 mU/ml, Alkaline phosphatase 1350iu/L. Urine showed traces of bile and urobilinogen. Gamma glutamyl transpeptidase was 584 iu/L (N = 24-48). Alkaline phosphatase fractionation was reported as showing two liver isoenzymes. Lumbosacral spine pelvic roentgenograms and bone scan were normal. Numerous serological and microbiological studies were unrewarding. Cytological examination of the sputum revealed malignant cells with epidermoid features. However, before specific therapy could be instituted, the patient expired.

Autopsy showed the following: (1) Poorly differentiated large cell carcinoma of the left upper lobe, with foci of extension to lower lobe, cancer pneumonitis, fibrosis, large areas of necrosis with cavitation, and vascular and lymphatic invasion by the neoplasm. (2) Metastatic spread to the opposite lung and all groups of lymph nodes above and below the diaphragm, to the adrenals, liver and bones. (3) No evidence of Hodgkin's Disease was found.

Discussion

Second malignancies in patients

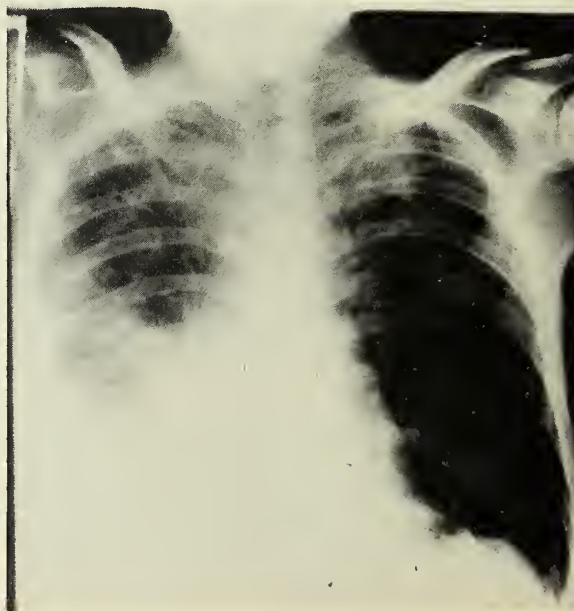


Figure 2
PA chest Xray in
May, 1977, show-
ing extensive pul-
monary infiltration
with a questionable
cavitory lesion in
the right upper
lobe.

with lymphomas have been noticed with increasing frequency and with an incidence higher than that in the general population.^{2,7-14} In one series reported by Razis *et al.*,² among 1102 cases of Hodgkin's Disease, 24 second malignancies were detected, an incidence of 2.2%. There were various carcinomas, one malignant melanoma, an osteogenic sarcoma and a Kaposi's sarcoma. Only one of these was a bronchogenic carcinoma. In Moertel and Hagerdom's series¹ of 826 patients with Hodgkin's Disease, the incidence was 1.6%. A search in the literature revealed only three instances of bronchogenic carcinomas, while there were 81 other neoplasms, among a representative population of 4888 cases of Hodgkin's Disease.^{2,7} This is an incidence of 0.3%. In contrast, the incidence of lung cancer, compared to other neoplasms in the general population, is 22% for men and 7% for women, according to the American Cancer Society's sta-

tistics for 1978. Therefore, despite an overall increase in incidence of second neoplasia in Hodgkin's Disease, bronchogenic carcinomas are detected only rarely. Whether this is a truly low incidence or a low one due to lack of clinical suspicion, is not clear. Our case brings out the difficulties involved in diagnosing bronchogenic carcinoma in patients with a prior malignancy, and in particular, in patients with Hodgkin's Disease, which is known to invade lung tissue with relative frequency.

In this patient, a liver biopsy had confirmed involvement by Hodgkin's Disease. Later, the bilateral pulmonary infiltrates with questionable cavitation demanded exclusion of TB and the mycoses. Once these were ruled out, pulmonary Hodgkin's Disease was considered very likely. This finding of malignant cells raised suspicion of another malignancy, but the possibility of Hodgkin's Disease involvement of lung parenchyma was thought more likely. Positive spu-

tum cytology has been found useful in diagnosing Hodgkin's Disease.^{5,6} However, the hepatosplenomegaly, the pulmonary infiltrates and the bone pains all proved to be secondary to bronchogenic carcinoma in this patient. The etiologic significance of the cytotoxics and radiotherapy, and the history of smoking in this patient, is speculative. While many questions remain unanswered, this case underlines the need for considering a second neoplasia in cases of lymphomas with unexplained features, particularly after treatment with cytotoxics and/or radiation. A case may also be made for employing sputum cytology in all cases with pulmonary involvement.

References

A complete list of references for "Bronchogenic Carcinoma in a Patient with Hodgkin's Disease: Case Report," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Hypersensitivity Reactions and Cytotoxic Effects

BY ROBERT H. SWANBORG, PH.D. AND NOEL R. ROSE, M.D., PH.D.

Some of the most important immune reactions, such as the destruction of tissue grafts and tumors, are due to the cytotoxic effect of cells, especially lymphocytes. The mechanisms through which the lymphocytes mediate these immune phenomena are not entirely clear, but it is likely that several are involved, including both the production of soluble mediators and the direct interactions between lymphocytes and the target tissue cells. With respect to the latter mechanisms, several *in vitro* models have been developed that show that immune lymphocytes are capable of destroying target cells directly, without the apparent involvement of soluble mediators. The lysis of target cells by immune cells is referred to as cell-mediated cytotoxicity (Figure 1).

Several methods have been devised to study cell-mediated cytotoxicity *in vitro*. They include the microcytotoxicity assay in which effector lymphocytes are added to monolayer cultures of target cells bearing the relevant antigen against which the effector cells are immunized or sensi-

tized. Obviously this method is useful only in systems in which the target cells can be grown on monolayers. After incubation for 48 to 72 hours the cells can be examined microscopically, and cytotoxicity is evidenced by the destruction of the monolayer. A drawback to this method is the possibility of nonimmunologic damage to the monolayer by factors such as enzymes released from dying cells in the culture. Moreover, quantitation is difficult since evaluation of monolayer damage is subjective.

The second procedure for detecting cytotoxicity involves the measurement of release of radioactive markers from labeled target cells in the presence of appropriate effector cells. Although several isotopes have been employed in this method, radioactive chromium (^{51}Cr) has been found to be particularly useful for labeling target cells. For example, the target cells can be labeled by incubation in nutrient medium with inorganic ^{51}Cr (usually in the form of $\text{Na}^{51}\text{CrO}_4$); the ^{51}Cr binds to proteins and other constituents of the cells. The release of label into the supernatant provides a sensitive and reproducible index of cell damage. It is, of course, important to select a target cell that takes up and retains ^{51}Cr . Thus, one must make sure in advance that spontaneous release levels are well below 2% per hour. Moreover, the target cell membrane must be susceptible to effector cell damage, as reflected by specific release of ^{51}Cr . An advantage to the use of ^{51}Cr over other radioactive isotopes is that released label is generally not reutilized by other target cells in the system. A variety of target cells have been successfully employed in this procedure, and there is no requirement that the cells grow on monolayers. Indeed, target cells in sus-

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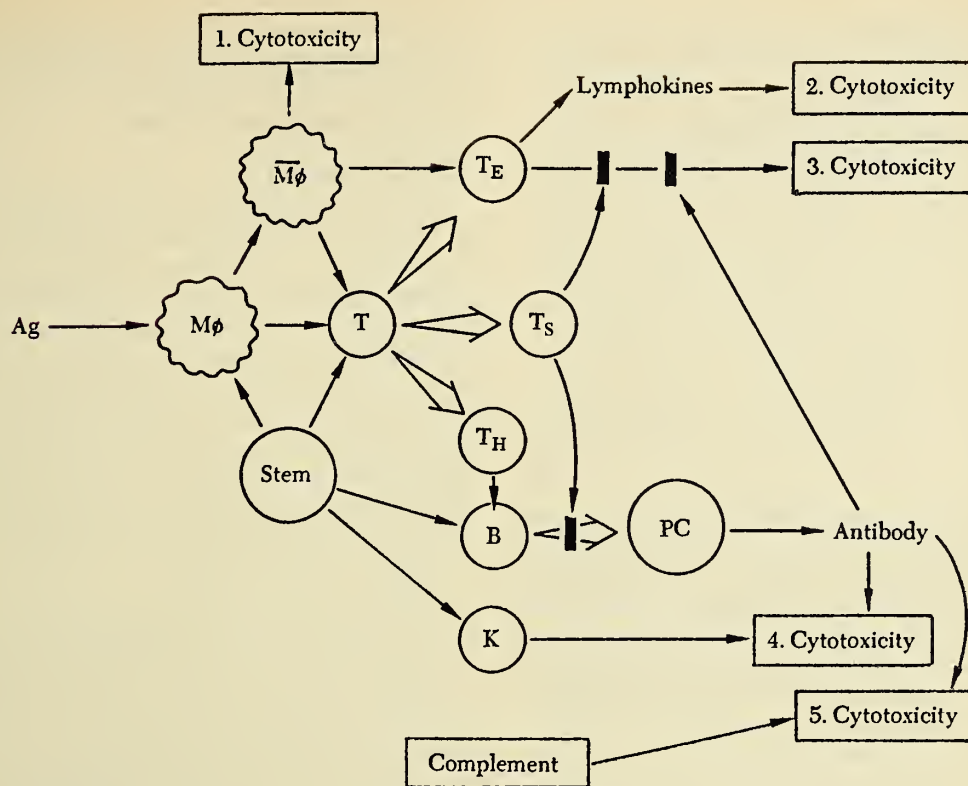


Figure 1

Mechanisms of cytotoxicity. Cytotoxic effects may be exerted by (1) activated macrophages, (2) cytotoxic lymphokines, (3) effector T cells, (4) antibody and K cells, (5) antibody and complement. Ag = antigen; Mφ = macrophage; $\bar{M}\phi$ = activated macrophage; T = T cell; T_E = effector T cell; T_S = suppressor T cell; T_H = helper T cell; B = B cell; K = K cell; PC = plasma cell.

pension appear to be more susceptible to effector cell lysis than are cell monolayers, presumably owing to increased target cell-effector cell contact.

Members of our team have recently found that radioactive indium (^{111}In) is also useful as a label in cytotoxicity reactions. It has the advantage of allowing the investigator to perform long-term assays (48 hours) to distinguish induced from naturally occurring cytotoxic effects.

Release of radioactive label into the supernatant is proportional to the percentage of cytotoxicity and gives a relative estimate of the frequency of cytotoxic cells in the effector cell population. In this procedure the percentage of lysis is linear with respect to the logarithm of the effector cell concentration. Cerottini and Brunner have defined the number of effector lymphocytes necessary to obtain 33% cytotoxicity (i.e., lysis) as 1 lytic unit.

Several cell types have been observed to function as effector cells in cell-mediated cytotoxicity including thymus-dependent (T) lymphocytes, thymus-independent lymphocytes referred to as "null" or killer (K) cells, and, in certain circumstances, monocytes and macrophages. In some parasitic infections, eosinophils have been implicated as the effector cell.

T Cell Cytotoxicity

In this system the sensitized T lymphocytes interact directly with the target cell bearing the corresponding antigenic determinants. Destruction is carried out without antibody or complement. Indeed, antibody may actually inhibit T cell-dependent cytotoxicity. Close contact between the T effector cell and the target cell is required.

Evidence that the effector cell in this system is a T lymphocyte is derived from several types of experiments. For example, T cell-dependent cyto-

toxicity can be abrogated by treating the effector cell population with anti-T-cell serum plus complement in studies carried out in the mouse, whereas anti-B-cell or anti-plasma-cell sera are not effective in preventing cytotoxicity. Moreover, removal of B cells on anti-immunoglobulin immunoadsorbent columns does not interfere with the cytotoxic response. Cytotoxic T cells are produced in mice and rats following tissue transplantation and also following immunization of animals with certain kinds of tumor cells.

In the mouse, the progenitor of the cytotoxic T cell appears to be a small lymphocyte that can be found in the spleen, lymph node, peripheral blood, thoracic duct, and thymus but is not usually found in the bone marrow. Cytotoxic cells can be detected three to four days after a tissue graft is placed. The early cytotoxic effector cell is a lymphoblast that is found in the peritoneal exudate fluid, blood, thoracic duct, spleen, and lymph node, (in decreasing order of frequency) but not in the thymus. Later, another cytotoxic cell with the appearance of a small lymphocyte can be found. Moreover, cytotoxic T cells can be elicited *in vitro* provided macrophages are present in the cell population. Recently it has been found that 2-mercaptoethanol can replace the requirement for macrophages in production of cytotoxic T cells *in vitro*.

As mentioned above, close contact between the cytotoxic T cell and the target cell is required for killing to occur. Dosage studies suggest that one cytotoxic T cell is capable of killing more than one target cell. The reaction is temperature dependent, proceeding most efficiently at 37°C. Although cytotoxicity fails to occur at 4°C, contact between effector cell and target cell can be observed at that temperature. This observation suggests that cell contact is not sufficient for target cell destruction, and that the cytotoxic T cell must be both viable and metabolically active in order to effect cytotoxicity. In support of this hypothesis are the findings that cytotoxic actions of T cells are impaired by inhibitors of RNA or protein synthesis but not by irradiation. The finding that cytotoxicity is also inhibited by the chelating agent EDTA suggests that divalent cations are required in the cytotoxic process.

With respect to the specificity of T cell-mediated cytotoxicity, it has been established that immune T cells lyse target cells with the corresponding histocompatibility (HLA) antigen on their surface but have less effect on unrelated target cells included in the same culture. This finding shows that soluble mediators are not in-

involved in the cytotoxic process unless, of course, they are relatively short-range mediators that act at the surface of the contact between the cytotoxic T cell and the target cell.

K Cell Cytotoxicity

It has been determined by Perlmann and his colleagues that lymphocytes from normal donors in the presence of immune serum are capable of exerting cytotoxic effects on target cells to which the antibodies are directed. This antibody-dependent, cell-mediated cytotoxicity, referred to as K cell lysis, can be seen in heterologous systems, for example, in which normal human lymphocytes are capable of lysing chicken red blood cells coated with rabbit antichickens red blood cell IgG antibodies. Moreover, K cell lysis can also be observed within the same species in the human, mouse, and rat.

Evidence that the effector cell is not a T cell comes from the finding that K cell cytotoxicity is not impaired if the effector cell population is treated with anti-T-cell serum plus complement, and from the finding that K cell cytotoxicity does occur in hosts that are deficient in T cells, for example, in thymectomized rats. The K cells can be removed on anti-immunoglobulin (Ig) immunoadsorbent columns but not on anti-Ig Fab columns. (Fab is the fragment of the immunoglobulin molecule that is capable of reacting specifically with an antigen; Fc is the opposite end of the antibody molecule and frequently reacts with receptors on tissue cells.) The latter finding suggests that the K cell is not an immunoglobulin-positive cell but probably bears an Fc receptor.

Therefore, the K cell appears to be an Fc receptor-bearing IgG-negative cell. It does not correspond to classical T cells or B cells and is sometimes referred to as a "third population" of lymphocytes.

K cell cytotoxicity is induced by antibodies of the IgG class that are specific for the target cell. The antibodies must possess intact Fc regions, which serve to attract the K cells through interaction with their Fc receptors. Thus antibody provides the link between target cell and effector cell and also ensures specificity for the system. Very few antibody molecules are needed for K cell cytotoxicity, probably in the order of a few hundred molecules/target cell. Frequently, anti-serum dilutions of 10^{-5} to 10^{-7} are effective, illustrating the high sensitivity of the system. Moreover, excess antibody inhibits cytotoxicity as does aggregated immunoglobulin or antigen-antibody

complexes in which the antigen is unrelated. The mechanism of this inhibition is presumably the blocking of the Fc receptor of the K cell. In the human, K cell cytotoxicity requires IgG antibody. With few exceptions IgM-class antibody does not mediate K cell cytotoxicity but may actually inhibit ^{51}Cr release. Complement is not involved in this phenomenon.

With respect to the mechanism of K cell cytotoxicity, close contact between the effector cell and the target cell is required. Studies by scanning electron microscopy with a plaque assay revealed that the K cell develops uropods that attach to the target cell and ultimately lyse the latter. The K cell is then free to lyse other target cells. When lymphocytes are responsible for antibody-dependent, cell-mediated cytotoxicity, lysis cannot be equated with phagocytosis. However, since other cell types, e.g., macrophages and monocytes, also bear Fc receptors, they are sometimes capable of functioning as effector cells. In the case of cytotoxicity mediated by macrophages, phagocytosis may accompany lysis. Specific chromium release can be seen within one hour and increases in linear fashion if the effector cell is a true lymphocytic K cell. In the case of macrophage or monocyte-mediated cytotoxicity, lysis exhibits a rapid onset and stops in a few hours. In immune reactions to animal parasites like schistosomes, eosinophils have been reported to act as antibody-dependent killer cells.

The K cell must be viable and metabolically active, although protein synthesis may not be required for cytotoxicity. Despite the observation that monocytes and macrophages sometimes exert effector function, the finding that purified lymphocyte preparations (>98% lymphocytes) are highly active rules out the possibility that K cell cytotoxicity is due only to these contaminating cells in the effector cell population.

The specificity of K cell cytotoxicity is due entirely to the antibody involved. The K cells can even be of heterologous origin. Studies with mixed populations of target cells, i.e., mixtures of target cells bearing different surface antigenic determinants, reveal that target cell lysis is confined to cells bearing an antigen corresponding to the specificity of the antibody present. Such studies also tend to exclude the involvement of long-range soluble mediators in the cytotoxic process.

Summary

Living target cells are susceptible to the action of lymphocytes and occasionally other cells. As illustrated schematically in Figure 2, at least two

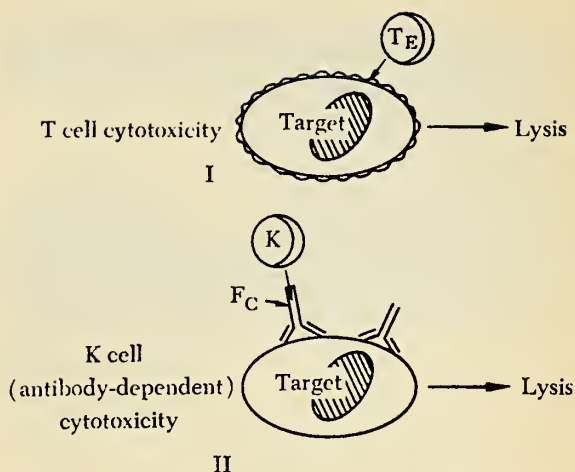


Figure 2

Schematic representation of effector/target cell interactions leading to cell-mediated cytotoxicity. The cytotoxic T cell (I) presumably recognizes a complementary antigenic determinant on the target cell membrane. In contrast, the K cell (II) interacts with the Fc fragment of an antibody molecule that has bound to a determinant on the target cell.

mechanisms of lymphocyte-mediated target cell killing are known. Sensitized T cells are capable of interacting directly, presumably by virtue of membrane receptors for antigen, with relevant target cells. On the other hand, nonimmune Fc receptor-bearing lymphocytes (K cells) have the capacity to interact with the Fc fragment of IgG antibody bound immunologically to target cell-bound antigenic determinants. The result of both cell-cell interactions is lysis of the target cell. T cell and K cell cytotoxicities have been shown to operate *in vitro* in numerous immune systems, including allograft and tumor rejection and autoimmune disease. ◀

Bibliography

- Biberfeld, P., Wahlin, B., Perlmann, P., and Biberfeld G.: "A Plaque Technique for Assay and Characterization of Antibody-Dependent Cytotoxic Effector (K) Cells," *Scand. J. Immunol.*, 4:859, 1975.
- Cerottini, J.-C., and Brunner, K.T.: "Cell-Mediated Cytotoxicity, Allograft Rejection, and Tumor Immunity," *Adv. Immunol.*, 18:67, 1974.
- Frost, P., Wiltout, R., Maciorowski, Z., and Rose, N.R.: "An Isotope Release Cytotoxicity Assay Applicable to Human Tumors: The Use of $^{111}\text{Indium}$," *Oncology*, 34:102, 1977.
- Perlmann, P.: "Cellular Immunity: Antibody-Dependent Cytotoxicity," In Bach, F.H., and Good, R.A. (eds.), *CLINICAL IMMUNOBIOLOGY*. Academic Press, New York, 1976, 107-132.

Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

Arthritis With Mass On Chest X-Ray

CASE PRESENTATION

A 44-year-old housewife was seen for a symmetric polyarthritis. Three months earlier she had noted pain and swelling of wrists and ankles which progressed to involve both knees and the small joints of her hands. The skin appeared reddened and swollen about these areas, extending over the dorsum of both hands and feet and associated with frank edema about the ankles. There was tenderness to even light touch and minimal motion. Concomitant with these changes she had also noted enlargement of the tips of her fingers and toes.

A five pound weight loss had occurred and the patient complained of easy fatiguability. A low-grade fever was occasionally noted. Medicines included a non-narcotic analgesic and a thiazide diuretic, which had no effect on the swelling. There was no prior history of joint disease. Other review of systems and past history were unrevealing.

On examination, moderate clubbing of fingers and toes was evident. Warmth, erythema and swelling were noted about ankles, knees and wrists with tenderness and limitation of motion demonstrable. Swelling was particularly prominent over the dorsum of the hands and about the ankle, where frank edema of subcutaneous tissues was observed extending beyond the joint margins on to the distal ends of the tibia and radius. Fluid was noted in both knees. Other examination was unremarkable.

Laboratory

Hemoglobin was 9.7, hematocrit was 29.6%. White blood cell count was 9700 with a normal differential. SMA 18, coagulation profile, urinalysis and EKG were normal. Sedimentation rate was 85 mm/hr Westergren, and complement levels were normal. Chest X-ray revealed a 5x6cm

irregular mass in the left upper lobe near the midline; no pleural effusions or atelectasis were noted. X-rays of the extremities (Fig. 1 & 2) revealed extensive periosteal reaction and new bone formation along the shafts of the distal radius, ulna, femur, tibia and fibula bilaterally. Such changes were also noted along metacarpals and proximal and middle phalanges of both hands. The joints themselves appeared normal. Synovial fluid from the right knee revealed clear straw colored fluid with good viscosity; negative gram stain and sterile cultures; white cell count 2050 with 16% polymorphs and normal glucose.

Comment

Hypertrophic osteoarthropathy is a syndrome of musculo-skeletal manifestations including variable combinations of clubbing of fingers and toes, periosteal inflammation and osseous proliferation, and periarticular and synovial inflammation.¹⁻³ Pain, swelling and erythema about the ends of long bones corresponding to periosteal reaction are the most common presenting signs. Patients complain of aching, burning and tenderness about these areas. Usually the distal radius, femur and tibia are involved, but occasionally small bones of hands and feet are similarly affected. Such changes may mimic cellulitis, arthritis or generalized edema from many causes. X-rays of involved areas reveal characteristic periosteal reaction and new bone formation, and bone scans reveal a diagnostic pattern of uptake about the distal ends of many long bones. Frank arthritis with synovial fluid accumulation may occur, and may simulate common rheumatic syndromes (i.e., rheumatoid arthritis, gout) depending on the joints involved. Synovial tissue shows a round cell infiltrate similar to that seen in the periosteum, and synovial fluid is non-specific and

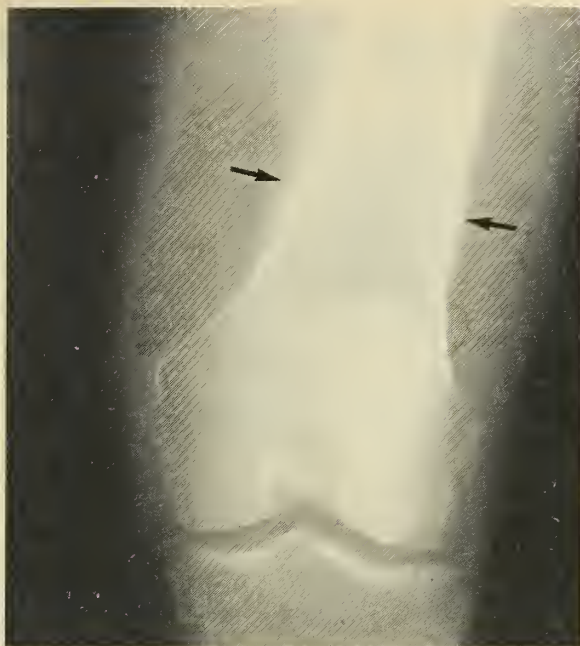


Figure 1

Typical periosteal new bone formation can be seen about the distal end of the femur (arrows).

non-inflammatory in character.³ Clubbing, often the earliest and only finding, may be insidious in onset and not noticed by the patient. Occasionally, other symptoms such as profuse sweating, fever and gynecomastia may accompany the syndrome.

Cause of hypertrophic osteoarthropathy is obscure. It is generally associated with an underlying disorder, most frequently with intrathoracic disease. Its presence has been noted in up to 10% of pulmonary neoplasms, bronchogenic carcinoma and pleural mesothelioma being the most common. Metastatic disease as well as other malignant, inflammatory and infectious pulmonary conditions have also been reported. Chronic diseases of other organ systems including bowel, liver and cardiac disorders have also underlied the syndrome. Because of this, such illnesses should always be considered and sought when clubbing or other manifestations of hypertrophic osteoarthropathy are present. A familial syndrome unassociated with any underlying disorder has been defined. This presents chiefly in prepubertal males. A few cases of the syndrome are idiopathic without obvious underlying genetic or pathologic predispositions.

Treatment is symptomatic. Non-steroidal anti-inflammatory agents such as indomethacin or as-



Figure 2

Similar changes are noted about the metacarpals and proximal phalanges, and near the distal end of the ulna (arrows).

pirin often are effective in alleviating symptoms. Occasionally systemic corticosteroids are necessary. Intrathoracic vagotomy has induced remissions⁴ and as such has caused speculation about the cause of the syndrome but is infrequently used as a therapeutic modality. Successful treatment of an underlying infection or neoplasm often provides dramatic relief of musculo-skeletal symptoms. Interestingly, recurrence of hypertrophic osteoarthropathy symptoms often heralds a recurrence of the underlying disorder.

Conclusion

Typical clinical and radiologic findings in the extremities together with a mass on chest X-ray suggested pulmonary hypertrophic osteoarthropathy in the present case. Bronchoscopic examination revealed necrotic material in the left upper lobe and was non-diagnostic pathologically. At thoracotomy a bronchogenic carcinoma was found and a left upper lobectomy performed. Post-operatively the patient was placed on indomethacin for control of musculo-skeletal symptoms with good response. Three months later, an exacerbation of these symptoms occurred concomitant with the discovery of metastatic disease in her liver. ◀

References

1. Howell, P. S.: "Hypertrophic Osteoarthropathy," in Hollander, J. L. and McCarty, D. J. (ed) *ARTHRITIS AND ALLIED CONDITIONS*. Philadelphia, Lea and Febiger, 1972.
2. Holling, H. E. and Brodey, R. S.: "Pulmonary Hypertrophic Osteoarthropathy," *Jama* 178:977-982, 1961.
3. Schumacher, H. R.: "Articular Manifestations of Hypertrophic Pulmonary Osteoarthropathy in Bronchogenic Carcinoma," *Arthritis Rheum.*, 19:629-636, 1976.
4. Holling, H. E., Brodey, R. S., Boland, H. C.: "Pulmonary Hypertrophic Osteoarthropathy," *Lancet* 2: 1269-1274, 1961.

An Interview With ISMS' Committee On Continuing Medical Education Accreditation

This summer, ISMS published the third manual on CME Accreditation since accepting AMA's 1971 invitation to survey intra-state CME sponsors. This third edition marks another major step by ISMS in adapting CME accreditation to the reality of physician learning patterns; it also reflects national policy shifts. To provide an overview of these changes, ICCME staff arranged this IMJ interview with the members of last year's ISMS Committee on CME Accreditation: Dean Bordeaux, M.D., M.A. (Educ.), Peoria, Chairman; Philip D. Anderson, M.D., Chicago; Allan C. Campbell, M.D., Peoria; Julius S. Newman, M.D., Aurora; and Warren D. Tuttle, M.D., Harrisburg.

For a copy of the new accreditation handbook, write or call: Illinois Council on Continuing Medical Education, 55 E Monroe Street, Suite 3510, Chicago, IL 60603; telephone (312) 236-6110.

IMJ: What major changes are reflected in the new CME accreditation manual?

Dr. Bordeaux: First, there's now greater emphasis on precise audience-specification and that specific audience's learning needs. Second, we ask each sponsor to formulate overall program goals and learning objectives, partly as priority guidelines for program-planning and more importantly as the baseline for evaluation of learner achievement. Third, we've combined two previous forms (the former application and the survey team report) into a single self-analysis with prescribed point values for various items. This should help each applicant plan CME in accord with what is known about physician learning. Fourth, we refocused the evaluation criterion to require documentation of a good-faith effort to assess learner achievement of stated goals regardless of the outcome, negative or positive.

IMJ: Does this mean you revised the Illinois criteria for CME accreditation?

Dr. Newman: Yes, in a backward fashion. We initiated the process for two reasons, both related to lack of specific operational standards for accreditation decisions. Site visit surveyors were not clear on what they should emphasize in their reports—chiefly because we weren't quite clear on what we wanted to know. Likewise, it was not always clear to sponsors what they should emphasize in their applications. So, we began our revisions in 1976 with a check-off survey report form derived from the open-ended reports surveyors had written in earlier years. Over the suc-

ceeding two years, this evolved into the new self-analysis that Dr. Bordeaux mentioned. Once satisfied at the operational level, we revised the criteria to fit the reality of how physicians actually conduct CME programs and how physician-surveyors judge educational efforts.

Dr. Anderson: Another important new feature is the style of the revised criteria. After we changed basic requirements, we asked the Illinois Council on Continuing Medical Education to draft explanatory statements for each criterion. The result is a brief "textbook" on how to plan effective learning for physicians. I've already used an early draft of this text as a study manual for my hospital's CME Committee and found it to be valuable.

Dr. Bordeaux: Learning about CME was established in 1972 as a central aim of CME accreditation in Illinois by the first ISMS Committee on CME Accreditation, chaired by Dr. Herschel Browns. Our three-year revision effort has built on early experience to carry that aim several steps forward.

IMJ: Were there other factors that required this major revision?

Dr. Newman: First, national authority for accreditation shifted as of July 1, 1977, from the AMA to a new federation, the Liaison Committee on Continuing Medical Education. Secondly, the Board of Trustees and the House of Delegates have made several policy decisions that should be reflected in both the criteria and in

procedural rules.

Finally, the Illinois Department of Registration & Education inaugurated a CME license-renewal requirement as of January 1, 1978.

Dr. Bordeaux: Our prime concern is to improve the quality of the accreditation process, to be objective with each sponsor reviewed, so site visit surveyors and our committee can make valid distinctions between good programs and the occasional poor one; and, quite importantly, to make the accreditation process an effective learning experience. As a committee, we have to make judgments on program quality—but we're happier when our authority can be used to help sponsors improve the quality of CME offered to physicians.

IMJ: You mentioned the Liaison Committee. What is its role?

Dr. Newman: As I mentioned, the Liaison Committee is now the national authority for CME accreditation. It arranges for surveys of national sponsors—medical schools, national specialty societies and voluntary health associations, and similar organizations. Local sponsors—community hospitals, state and local societies—are surveyed by their respective state medical associations. Our role is to recommend to the Liaison Committee; the Liaison Committee makes final decisions.

IMJ: We understand that the new self-analysis form is over 30 pages long. Does this impose an undue burden on sponsors, especially smaller hospitals and societies?

Dr. Tuttle: I joined the committee late last year, and attended the last two of several meetings devoted to detailed review of this new form and the new criteria and rules. Because I was new at the job, maybe I have a clearer perspective. My impression is that the new self-analysis is a valuable self-learning instrument. We approved the third version on a trial basis in February. While it's somewhat long, we did shorten it from the first and second versions. We now want to use it on a wide scale to determine which items help surveyors and our committee make recommendations, and which items are redundant or possibly not needed. A related issue, however, is the learning function of the self-analysis. It's designed as a check-off list to help physicians who serve as CME planners. A number of items without point values are included to remind sponsors of important steps in the CME planning process.

IMJ: You mentioned a change in the evaluation criterion. Did you lower the standard?

Dr. Campbell: No, we think we made it more realistic. Often, it's not possible to relate changes in physician performance to specific learning activities. On the other hand, evaluation as an educational technique is crucial feedback to both the CME planner and program participants to answer the question: What did we learn? If the answer is negative, planner and participants have clear evidence of the need to change something in the learning program.

Dr. Anderson: In fact, I think we made the evaluation requirement more rigorous by prescribing well-defined overall program goals and learning objectives. Evaluation is a long-term effort—one to two years, or longer—to ascertain learner achievement of stated goals and objectives. As a hospital Director of Medical Education, I can reflect from personal experience on Dr. Campbell's point about the difficulty of educational evaluation with a group so highly educated as physicians. So, we ask for rather specific goals—and then demand a good-faith effort to document achievement or non-achievement by the specified audience. We do not take a negative view of nonachievement; that information is good feedback. What is important is that evaluation be done.

IMJ: Do you have any evidence on the usefulness of the new self-analysis?

Dr. Bordeaux: Yes, we do. As Dr. Tuttle remarked, the form approved in February is the third version. The first version was tested at the annual Surveyors Workshop in April, 1978, and revised on the basis of surveyors' comments and suggestions. The second version was field-tested during the summer and fall of 1978, and feedback from those tests was considered as we developed the third trial version.

What we heard repeatedly from CME sponsors who tested the form was that valuable ideas had been gained from the alternative check-off statements reporting how other sponsors conduct CME. Surveyors on these field tests reported that they found it easier to use than the old separate application and survey report forms.

Neither funds nor staff have been available for a scientific study of the validity of specific items and the entire self-analysis. Instead, we have re-

lied on the judgments of surveyors, who include physicians with competence both in clinical medicine and in the academic discipline of education. One anecdote from last year's field-testing provides negative evidence that reassures us. Each sponsor, whether new or renewal, was invited to join the test and also informed that it could use the old application for accreditation. One sponsor—a major teaching hospital with a paid DME—agreed to test the self-analysis, but subsequently submitted the old application for accreditation. This application on the old form reflected such poor program planning that the surveyor and our committee recommended "Non-Accreditation." We take that as evidence that the DME in this instance was not willing to think through the problem of physician learning well enough to warrant gaining CME accreditation.

IMJ: Has the Liaison Committee made many changes from the previous AMA system?

Dr. Newman: No basic change in requirements for accreditation—but a number of changes in procedure. The major change is that it abolished a pre-determined "expiration date" for accredited status; instead, each sponsor remains accredited

until that accreditation is withdrawn by official action of the Liaison Committee. Resurvey is prescribed for two or four years after each Liaison Committee decision to insure regular review of accredited sponsors. The net effect is to lengthen each period of accredited status slightly, and—more important—avoid any hiatus in accredited status. They also recently adopted a feature that ISMS adopted in 1977—initial accreditation is effective as of date of the site visit.

IMJ: Was this new procedure and form developed only by your committee?

Dr. Bordeaux: By no means. Our best estimate is that about 150 different people were involved in varying degrees over a three-year period; and we are grateful to every one of them. We owe special gratitude to a former member of this committee, H. Close Hesseltine, M.D., whose wisdom and insight were of immense value. I am convinced that we now have a most useful and valid procedure for CME accreditation. I am equally convinced that the major reason for its high quality is the large number of people—many of whom are producers of CME programs—involved in the development of this new system. ◀

Viewbox

(Continued from page 95)

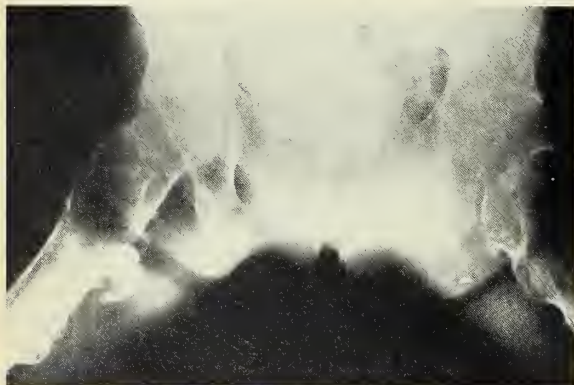


Figure 2—Pelvis and Femurs

DIAGNOSIS: Chondrosarcoma

In Figure 1 there is an anterior mediastinal mass displacing the trachea. The mass could be any of the five choices. The first four represent the most common anterior mediastinal masses.

The fifth is very rare. This patient, however, has hereditary multiple exostoses and several bone lesions are seen in the chest film. (Fig. 1) In Figure 2 there is widening (undertubulation)

of the upper femurs and several exostoses of the femurs and ischium. The mediastinal mass is a chondrosarcoma which arose from a transverse process of the thoracic spine and compressed the superior vena cava.

Hereditary multiple exostoses is uncommon but not rare. It is more common in males. The bone lesions are not present at birth and are usually discovered in childhood as palpable masses. Symptoms may occur from pressure on adjacent structures. These benign osteochondromas may become malignant with an incidence of about 5%. Pain, growth of a lesion after epiphyseal closure, or radiographic change are suspicious for malignant degeneration.

In addition to exostoses, X-ray changes in this disease include undertubulation of long bone ends and wrist deformity consisting of a madelung type deformity plus a short ulna. ◀

References

1. Edeiken, J., Hodes, P.S., ROENTGEN DIAGNOSIS OF DISEASE OF BONE, Williams & Wilkins, Baltimore, 1973.
2. Aegerter, E., Kirkpatrick, J.A., ORTHOPEDIC DISEASES, W. B. Saunders, Philadelphia, Pa. 1975.
3. Tachdjian, M.O., PEDIATRIC ORTHOPEDICS, W. B. Saunders, Philadelphia, Pa. 1972.

Board Abstracts

(Continued from page 84)

HOUSE, BOARD MEETING DATES

The following dates and locations were selected for Board of Trustees and House of Delegates meetings:

House of Delegates

Nov. 10-11, 1979	Holiday Inn, Decatur (Interim Session)
Apr. 13-16, 1980	Pick Congress, Chicago (Annual Meeting)
Nov. 15-16, 1980	Peoria Hilton, Peoria (Interim Session)
May 17-20, 1981	Pick Congress, Chicago (Annual Meeting)

Board of Trustees

Sept. 15-16, 1979	Ambassador West, Chicago
Nov. 9-11, 1979	Holiday Inn, Decatur
Feb. 3-6, 1980	L'Enfant Plaza, Washington, D.C.
Apr. 12-16, 1980	Pick Congress, Chicago
June 28-29, 1980	To Be Announced
Sept. - 1980	To Be Announced
Nov. 14-16, 1980	Peoria Hilton, Peoria

JAIL HEALTH PROGRAM

The Board agreed to accept a \$39,285 grant from the Law Enforcement Assistance Administration—through AMA—to continue for another year the Society's implementation of the AMA Program to Improve Health Care in Jails. During the next year, the number of participating county jails will be doubled. Currently, five jails are involved in the program.

EKG

(Continued from page 92)

Answers: 1. A, B 2. E

The simultaneous leads V₁, II rhythm strip shows sinus rhythm with slight sinus arrhythmia and a rate of 75 beats/minute. There are also non-conducted P waves seen, *i.e.*, the 5th and 9th P waves. The PR interval prolongs with each conducted P wave leading to a P wave that fails to conduct. This is type I second degree AV block or Wenckebach block. It is atypical because the slight sinus arrhythmia throws the R-R cycles off and they do not shorten typically. This young patient had no other evidence of heart disease. All of the statements in question two are correct. The significance of heart block in the pediatric age group has been related to associated congenital heart lesions. In addition, AV Wenckebach has been described in physically

trained athletes. It is thought to be due to an increased vagal tone and is regarded as benign. In the pediatric age group, the symptomatology for complete heart block is related to associated congenital heart lesions and the rate and stability of the ventricular pacemaker. A recent paper by Young, *et al.*, (*American Journal of Cardiology* 40:393-9, 1977) has suggested that the occurrence of Wenckebach second degree AV block may precede the development of complete AV block in adolescents. This may be a phase in the natural history of idiopathic heart block. If so, the prognosis for symptomatic second degree Wenckebach block in children may not be so benign. Careful follow-up for our patient was the only treatment at this time. ◀



AAMA UPDATE

The AAMA certification program is now being administered by the Certifying Board, and the National Board of Medical Examiners serves as educational consultant. NBME is a nonprofit organization which prepares and administers medical and specialty board examinations.

Test questions are formulated by the Joint AAMA/NBME Task Force for Test Construction, working under the direction of the Certifying Board and NBME. This task force is composed of qualified medical assistants, physicians, and medical assisting educators.

Purpose of the Certification Program:

1. To uphold professional standards and goals established by the Association.
2. To help physicians identify competent medical assistants.
3. To certify those who successfully complete the examinations.
4. To encourage continuing education.

Current Certification Examination Categories:

(CMA)—Certified Medical Assistant; (CMA-A)—Certified Medical Assistant/Administrative; (CMA-C)—Certified Medical Assistant/Clinical; and (CMA-Ped.)—Certified Medical Assistant/Pediatric. (CMA-Ped.) had been offered previously, but has been discontinued and will be administered one more time in 1980.

A total of 898 Certified Medical Assistant certificates were awarded to successful candidates taking the basic Certification Examination on January 26, 1979. More than 2,700 candidates were scheduled to sit for the spring examination on June 1, 1979, for basic and specialty certification.

April 18, 1978, was a big day for AAMA. AAMA received notification from the Bureau of Manpower Development of the U.S. Dept. of Health, Education and Welfare that the medical assisting profession and its educational concerns have become eligible for federal grants. The new ruling means, specifically, that AAMA and medical assisting programs in institutions of higher

learning will have competitive access to grants for research, planning, and a variety of other educational endeavors.

April 18th, also saw a public relations coup. Statistics concerning the number of students enrolled in accredited medical assisting programs appeared on the front page of the Wall Street Journal.

During the 22nd Annual Meeting of the AAMA in Boston, The Continuing Education Board was established. The Continuing Education Board is comprised of practicing medical assistants, educators, and physicians responsible for developing and implementing policies and guidelines for the AAMA programs in continuing education. A Task Force has been assigned to develop program plans that can be implemented at the chapter or state society level. This is an effort to assist program chairmen with those subjects difficult, but necessary for a medical assistant's continuing education.

AAMA continuing education is growing; in fact, it is growing so rapidly that AAMA must stay abreast of more programs, keep track of more participants, and maintain more records on file. To meet this demand, the Continuing Education Board will be implementing a new record-keeping method in October, 1979. All records of participation in AAMA-approved programs will be maintained by the American College Testing (ACT) National Registry Service.

AAMA, Illinois Society, members are actively participating in the Continuing Education programs, and would like to invite all Illinois physicians to encourage their Medical Assistants to participate in the many continuing education programs.

For information regarding AAMA, Illinois Society, contact: Cissy A. Egly, C.M.A., president, 1413 S. Midland Manor, Joliet, IL, 60436, or Mrs. Luella V. Mitchell, 7920 Eberhart, Chicago, IL, 60619, chairman, Public Relations Committee. ◀

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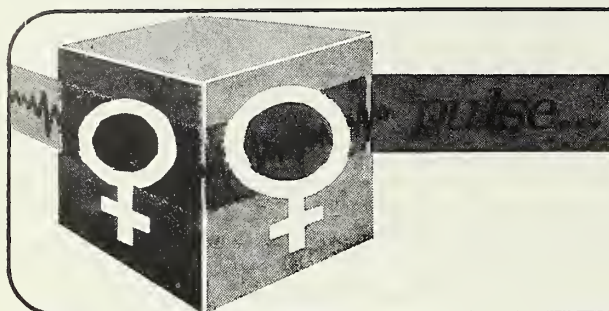
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April 1979



of the ISMS auxiliary



BY MRS. R. S. HOOVER, ISMSA
PRESIDENT

One Last Shot Don't Let The Bugs Bite

The house lights dimmed, the TV cameras clicked on; twelve precious nursery school children began their song. Each held a hand puppet, and with four-year-old enthusiasm shouted, "Don't let the bad bugs bite!" Stars of the show in Des Moines, Iowa, these children demonstrated the immunization project of the Polk County Medical Auxiliary. All around the United States, from Los Angeles to Boston, medical auxiliaries have been "pushing" immunization programs.

Two years ago, HEW set a goal to raise the immunization level to 90%—high enough to prevent epidemics—and to establish a permanent system to fully immunize newborns. A deadline date of October, 1979, was set. Progress made by volunteer groups, public health departments, and other organizations has achieved the following results: 90% of all children (seven diseases) entering school in six states, 90% in twenty six states (excluding mumps), 95% in four states and 100% in Alaska (excluding mumps). Many states have passed laws to prevent immunization levels from falling again. Illinois has a mandatory immunization law.

Dr. Thomas E. Nesbitt, AMA president, has said, "The immunization campaign, in my ex-

perience, was perhaps the most successful program that the AMA Auxiliary has conducted." High praise indeed, for the efforts of auxiliaries who have used more than 11,000 stencils on school yard hop scotch games, and 22,000 posters ("Don't Let the Bugs Bite") supplied by the AMA Auxiliary. Other auxiliary projects include comprehensive immunization awareness public relations programs, puppet shows, including Los Angeles' "Immuni-Theater," immunization audits of school records, distribution of immunization record booklets, sponsoring and staffing free immunization clinics, writing and distributing school materials, posters and information.

Twelve auxiliaries in Illinois were active in this area last year. Many of them used the hop scotch stencils for school playgrounds. Cooperating with county health departments and school nurses, auxiliaries have volunteered to aid in auditing immunization records. Lake County had an innovative program entitled the "Language Bank." Posters were distributed with the immunization message translated into foreign languages, Spanish, French, Japanese, Thai, etc., depending on the intended target ethnic group.

Information on immunization programs is readily available. The American Academy of Pediatrics immunization schedules were published in the May, 1979, *Illinois Medical Journal*. An immunization booklet that coordinates with the puppet theme has been published by the AMA. Other materials are available from the National League of Nursing, Inc., Childhood Immunization Community Action Kit, and from the Center for Disease Control, Immunization Division, Atlanta, Ga.

One source of information for Immunization Projects and other community projects is the AMA Auxiliary Project Bank Catalogue. This catalogue contains over 650 projects and is readily available. Each county auxiliary president as well as our State Health Projects Chairmen and Project Bank Chairmen have copies. The catalogue is revised and reprinted annually. Don't overlook this comprehensive and up-to-date source for community project ideas.

The catalogue contains a description of every project in the AMA Auxiliary's Project Bank, a clearinghouse of community service programs developed by local auxiliaries around the country. Nearly every type of health and welfare program is represented. Related subjects are also covered—fund raising, health careers, and activities of

interest to the medical community.

Projects in the Bank are obtained from local auxiliaries. When a state or county completes a project, it is reported to the AMA Auxiliary headquarters, where the project is put into a standard form, assigned a number and listed in the catalogue. Auxiliaries in search of a suitable project can look through the catalogue and request the project from national headquarters. The catalogue also contains a resource section which includes organizations offering information on health topics as well as package programs, films and book bibliographies, etc. (Descriptions of fifteen individual auxiliary projects for the immunization campaign are listed in the Project Bank Catalogue!)

Time is still left before the October deadline to give one last shot at the "bad bugs," polio, tetanus, mumps, rubella, diphtheria, measles, and whooping cough. A clinic could still be arranged. "Don't Let the Bugs Bite" posters could be distributed in supermarkets, doctor's offices, and other prominent community locations. A quick audit of kindergarten entrance records could be made. And, once the deadline has come, a continuing program of audits and awareness information could be an important contribution of your auxiliary. ◀

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The First-of-the-Year Syndrome

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey Holt, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

In going from the month of June to the month of July, we pass from working in familiar situations with people and responsibilities we know to sharing new responsibilities and tasks with new people. As one resident said: "As a medical student, I thought the most frightening experience in medicine was that of having to do a procedure I was not familiar with while the resident looked over my shoulder. As an intern, I found it was much *more* frightening to do a new procedure *without* anyone looking over my shoulder. As a resident, I have found it infinitely more terrifying having to watch someone do a new procedure when I know he's never done it before. As a Senior resident, I am sure I shall find that the most terrifying experience of all is tossing and turning at night worrying about what the junior residents are doing!"

RPS Wins Right to Fill Empty Alternate Delegate Slot

At the 1979 Annual Meeting of the Illinois State Medical Society, the ISMS House of Delegates voted to allow a resident member to fill an open Alternate Delegate slot to the AMA House of Delegates when an opening occurs.

The action of the house was: "**RESOLVED**, That this House of Delegates recommend to the AMA Delegation that the Resident Physician Section designate a resident physician member to fill any one vacancy in the Downstate AMA alternate delegation at any AMA meeting, and that the Student Business Session designate a student member to fill any one vacancy in the Chicago Medical Society alternate delegation at any AMA meeting. Such designated resident or student member would continue to serve as an alternate delegate until the regularly elected alternate delegate was able to serve."

The RPS has been requesting a Delegate slot to be assigned specifically to the RPS since the ISMS receives an extra delegate based upon the ISMS-RPS and SBS members. Although the ISMS-RPS still hopes eventually to obtain a separate allotted delegate, the recognition by the ISMS House of Delegates in the present form of an alternate interim appointment is nonetheless appreciated. The Illinois State Medical Society has been very helpful to its RPS group in organizational support; the society's confirmation of that support in the ISMS-AMA delegation affirms and strengthens that support. ◀



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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Internist with special interest in Cardiology. Good EKG volume, exclusive interpretation privilege. New 4 bed Special Care Unit. Some general practice required. Guaranteed Salary. Located within 35 minutes of Southern Illinois University Medical School Carbondale, Cape Girardeau, Mo. and Paducah, Ky. Contact: E. A. Helfrich, Adm. or Ken Simpson, Asst. Adm. Union County Hospital, 517 N. Main St., Anna, 62906. Telephone Collect: 618-833-5155 (12)

DANVILLE: More than would be expected in a city of 43,000. Area population of 190,000 served by two medium sized community hospitals. An industrial medicine specialist or a neurosurgeon would find above average opportunities for professional growth. Area offers all the advantages of a smaller city life plus easy access to major urban areas. CONTACT: Richard V. Liven-good, President, Lakeview Medical Center, 812 North Logan Avenue, Danville, 61832. (9)

FAIRBURY: Primary Care Physicians-excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (12)

FREEPORT: Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

MATTOON: Family practitioner or internist for rewarding primary care practice. Fully equipped office available—New 210-bed hospital (open staff)—Financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient draw of 75,000. Contact: A. P. Rauwolf, M.D., 1120 Wabash, Mattoon, 61938. (217) 234-6253. (10)

OBLONG: Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensation negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

OQUAWKA: Population of County—8,000. Opening in new medical clinic. Ninety-five miles from Peoria. Complete office facilities. Near colleges. All recreational fa-

cilities nearby. CONTACT: HENDERSON COUNTY HEALTH DEPARTMENT, P.O. Box 186, Oquawka, 61469, (309) 867-2202. (10)

SOUTHERN ILLINOIS: Opening in newly remodeled community Health Services Center located in Cairo adjacent to hospital. Target population 20,000. Six physicians, two dentists, counseling services, and outpatient lab at present. Financial assistance available. Near university and colleges. Wide range of recreational facilities. CONTACT: Steve Miller, 529 Cross St., Cairo 62914 (618) 734-4200 (8)

STERLING/ROCK FALLS: Primary Care physicians needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

SYCAMORE: Associate Desired—for July, 1980. Family practitioner to join two family physicians and internist in a newly formed group. Situated 112 kms west of Chicago in a semi-rural area. Family practice oriented hospital, with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D. (Director), 954 West State Street, Sycamore, 60178, (815) 895-9144. (9)

Sixth Annual Family Practice Review

Featured Speakers

William McCormack, M.D.
State Laboratory Institute
Boston, Massachusetts

Topics:

"Clinical Immunology As It Applies to the Rheumatic Diseases"

"Update on Current Medications Available for the Rheumatic Diseases"

J. Donald Smiley, M.D.
Dallas, Texas

Topics:

"Chlamydia, Non-Specific Urethritis"

"Urinary Tract Infection"

Featured Dinner Speaker: Mr. Roger Tusken
Executive Director of AAFP

Topic:

"Legislative Activities of the Academy in Washington"

Contact: S.I.U. School of Medicine
Post Office Box 3926
Springfield, IL 62708
Department of CME

September 20-21, 1979
Holiday Inn East, Springfield, Ill.
Fee: \$125

Doctor's News

PHYSICIAN ADVERTISING GUIDELINES AMENDED—The ISMS Annual Meeting House of Delegates amended Physician Advertising Guidelines adopted at the 1978 Interim Session. The action indicates that advertising of usual and customary fees for routine procedures and public announcement of fee changes is professionally acceptable. However, average charges may not be stated and fee identification must not be misleading. The complete guidelines will be incorporated in the ISMS Policy Manual, which is published in the October issue of *IMJ*.

IHFA MEMBERS CONFIRMED—The Illinois Legislature has confirmed appointments to the Illinois Health Finance Authority. Those voting members representing the public sector on the IHFA are: Allison S. Davis, a Chicago attorney; Phyllis Perkins, Winnetka, who has served on the Evanston Hospital Board of Directors, Martin J. Koldyke, Kenilworth, president of Frontenac Capital Corporation and Gregory A. Hasty, business manager for the North Central Illinois Laborers Council, in Peoria. Joseph B. Fitzer of Chicago, retired senior vice president for Continental Bank, was named to represent hospital trustees.

Non-voting members representing hospital administrators are Kenneth C. Etcheson, Canton, administrator of Graham Hospital and Donald R. Oder, Deerfield, senior vice president and treasurer at Rush-Presbyterian-St. Luke's Medical Center. Non-voting members representing third-party payors are Charles R. Goulet, Geneva, president of HMO Illinois, Inc., Blue Cross/Blue Shield, Chicago and Chester M. Karol, Skokie, director of field claim administration for Washington National Insurance Company in Evanston.

The IHFA was established by the legislature in 1978, and come into effect January 1, 1979, to establish prospective hospital rates on the basis of reported charges by individual hospitals for specified procedures.

PRESCRIPTION DRUG ABUSE—The Illinois Dangerous Drugs Commission has created a Task Force to develop comprehensive legislative and regulatory recommendations for dealing with prescription drug abuse. The Task Force, which was formed with support of ISMS, will review existing laws and regulations governing prescribing practices and the availability of drugs, as well as problems of enforcement. It will consider appropriate indications for use of certain drugs, setting of professional standards, and disciplinary regulation of unscrupulous medical practitioners. The possible need for increased controls over manufacture and distribution of these drugs will also be studied.

CPT-4 AVAILABLE—The AMA has announced that the third edition of the Physicians' Current Procedural Terminology, the comprehensive system for naming, coding and reporting medical procedures and services, is now available. Over 100 revisions are included in this new edition. Revisions include those relevant to urology, radiology, orthopedics, immunology and several other specialties.

The new edition establishes a mechanism for additions or changes in the CPT. Lengthy waiting periods between editions will no longer be necessary.

CPT-4 may be purchased for \$12.00 (prepaid) through the AMA Order Department OP-41, Post Office Box 821, Monroe, WI 53566.

PHYSICIANS IN THE NEWS—At the recent annual meeting of the American Medical Association, ISMS Past President **Frank J. Jirka, Jr., M.D.**, Barrington Hills, was re-elected to the AMA Board of Trustees. At that same meeting, **Ira J. Isaacson, M.D.**, Chicago, immediate past chairman of the ISMS-RPS, was elected a member-at-large of the AMA-Resident Physician Section, and David Aizuss, Chicago, newly-elected chairman of the ISMS-SBS, was elected to serve as a member-at-large of the AMA-Student Business Section.

Former ISMS president **Caesar Portes, M.D.**, has announced his retirement from practice and resigned his position as medical director of Gottlieb Memorial Hospital in Melrose Park. Co-founder of the George and Anna Portes Cancer Prevention Center of Chicago, where he formerly served as medical director, Dr. Portes specialized in proctology. Dr. Portes was the first president of the Inter-Hospital Planning Association of the Western Suburbs and has also served as a professor of surgery in the Department of Proctology at the Chicago Medical School.

Another past president, **Fredric D. Lake, M.D.**, is a recent recipient of the Chicago Radiological Society's Gold Medal Award for outstanding service to the profession. Dr. Lake was also recently named chairman of the College's Commission on Internal Affairs which coordinates and oversees the activities of previously autonomous and new committees. He is immediate past president of the American College of Radiology.

The American College of Radiology has announced that five Illinois physicians have achieved the rank of fellowship. They are: **Leonard Berlin, M.D.**, Wilmette, **Manny N. Chudwin, M.D.**, Olympia Fields, **Arthur R. Crampton, M.D.**, Evanston, **Suresh K. Patel, M.D.**, Chicago, and **Hyo H. Byun, M.D.**, also from Chicago.

Karl W. Scheribel, M.D., Northbrook, was recently named chief of staff at the Loyola Medical Center, Foster G. McGaw Memorial Hospital. Dr. Scheribel was also appointed associate dean for professional affairs at the Loyola Stritch School of Medicine.

Robert E. Henkin, M.D., Hoffman Estates, director of nuclear medicine at the Loyola University Medical Center, has been elected vice president of the Central Chapter of the Society of Nuclear Medicine. The central chapter encompasses 2,000 physician members in Illinois, Michigan, Indiana, Wisconsin and Minnesota. . . . IDMHDD has announced that Robert Steck, M.D., has resigned as administrator of their Region 5 (southern Illinois). Dr. Steck will continue to serve as superintendent of the Anna Mental Health and Developmental Center.

MEDICAL MARIJUANA—The Illinois Dangerous Drugs Commission has announced that the FDA has approved DDC plans to obtain quality-controlled medication in the form of marijuana capsules and cigarettes from the National Institute on Drug Abuse. This will allow conduct of clinical investigations with the marijuana material in order to determine its effectiveness in controlling nausea and vomiting accompanying cancer chemotherapy. This action was taken in accordance with recent legislation in Illinois, and makes Illinois the first state in which the federal government has authorized that MD's can dispense and administer marijuana and its derivatives to cancer patients suffering chemotherapy side effects.

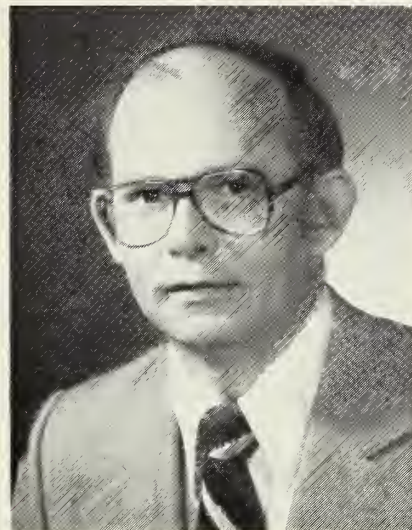
The Dangerous Drugs Commission has announced that physicians who have patients whom they feel might benefit from the research program may apply to DDC for participation. Application includes stringent eligibility criteria for both physician and patient. Upon approval of the application, DDC will supply the physician with appropriate dosages of medication and specific guidelines for the research project, which include explicit reporting requirements.

Initial research, DDC announced, will be conducted through the University of Chicago Hospitals and Clinics and the Illinois Cancer Council.

WORDS OR COMMITMENT?

"Without civic morality communities perish; without personal morality their survival has no value."

Bertram Russell, "Individual and Social Ethics"



It is an obligation of medical practice to exert peer pressure on colleagues. This is a time-honored means of protecting the public and profession from that small percentage of physicians who disdain the profession's ethical standards.

Peer pressure is difficult to define and quantitate. It also has the potential to be extremely elusive.

Recently, the lack of effective peer pressure has become glaringly evident. Why the erosion in ethical commitment? There is no definitive answer. However, the result is an abrogation of certain ethical responsibilities to the public sector.

We now have a State Medical Disciplinary Board with a duty to discipline physicians who practice marginal medicine. This transfer of responsibility seemingly has led many physicians to erroneously conclude that they no longer have an obligation to enforce professional standards.

Recently, front page news stories revealed that physicians—untouched by peer pressure—were allegedly indiscriminately dispensing drugs. In fact, law enforcement officials maintain that diversion of prescriptions is a major source of "street" drugs.

It is inconceivable that this type of practice—uncovered by a newspaper's investigative task force—went unnoticed by these physicians' peers. I am sure that is not the case. It was tolerated and ignored! This is a subordination of our ethical standards which we—as a community of physicians—cannot tolerate or ignore.

Each of us has a duty to initiate action regarding patterns of practice, quality of care and breaches of ethical standards.

Our ethics currently are being assailed in the courts. We are writing eloquent legal briefs defending the right and need for these standards. However, a legal victory will be shallow if we allow our ethics to become mere words on paper. They must be practiced and lived.

Failure to exercise our inherent responsibilities will generate more restrictions on medical practice. The by-product will be less creative medicine, less individual accountability and further dilution of the standards we now are fighting to preserve.

A handwritten signature in cursive script, reading "P. John Seward, M.D.".

P. John Seward, M.D., President

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Have you taken your pill?

Physicians everywhere are complaining about a new disease.

The malady first struck on a large scale in the 1930's. So subtle were its symptoms many thought it a blessing in disguise.

Since then, a different story has unfolded. A surge in lost work days, increased health care costs, and even a numbing of the senses to the point that millions have lost all motivation and spirit. . .all this and more has resulted.

It has even crept into physicians' offices forcing most to hire extra staff just to practice a form of preventive medicine.

The disease? Bureaucratic regulationitis.

Only one antidote is known to exist. If taken in large enough doses, it has even been known to cure cases in their advanced stages.

There is only one problem. The medication is contained in a material called politics. . .and some still consider this a health hazard.

Studies by physicians nationwide, however, prove the opposite is true. A sufficient number of case histories have now been developed to show politics is even essential for good health and well being.

So, if you haven't taken your medicine, do it today.

Herbert Sohn, M.D.

Chairman
Illinois Medical Political Action
Committee

P.S. Remember. . .you need a booster every year.

IMPAC

55 E. Monroe, Suite 3510
Chicago, IL 60603

Dear Doctor Sohn:

Please send me a year's supply of medication to treat me for bureaucratic regulationitis. I understand that in addition to the IMPAC cure I will also receive some help from AMPAC.

name _____

address _____

city, state & zip _____

- ☐ I am enclosing my check for \$25
☐ Please include a dosage large enough to protect my whole family. Enclosed is my check for \$45.
☐ Please send me a high potency dose called a sustaining membership. I am enclosing my check for \$99.

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Student Business Session in Action

Summary of Goals

In this column, the first for the new governing council of the ISMS-SBS for 1979-80, a statement of intent seems appropriate. We view ISMS-SBS as a valuable social, educational and organizational tool designed to enhance the transition from medical student to medical practitioner.

The work of the council offers interested students in the state of Illinois a chance to meet and exchange views with students outside their graduating classes. Further breadth of peer contact is available through the CMS, ISMS and AMA meetings which student members are eligible to attend.

Educational opportunities are offered at a variety of levels ranging from formal seminars/business meetings (which may be used for CME credit) to book, instrument and supply exchanges organized among the Illinois medical schools. Last year, for the first-time, we compiled a city-wide list of electives for upperclassmen in Chicago medical schools.

Legislative and public policy issues are still another concern of ISMS-SBS, as we offer the student an opportunity to see the forces governing medical practice at work. Contacts are made and maintained with medical lobbying efforts on both the state and national levels. A current focus of ISMS-SBS legislative activity is national AMA-SBS bylaw changes encouraging participation by members in resolution of policy questions. *Jama*, *American Medical News*, *Chicago Medicine* and the *Illinois Medical Journal* provide viewpoints on current social and legislative topics as well as technical subjects.

In summary, our intent is professional development. Development is impossible, however, without interaction and input from undergraduate and graduate medical professionals. We invite all to join us. ◀

David J. Dries
Secretary/Editor

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular

basis, and urges Illinois physicians to notify their patients of this service.

September 9	Seventh Day Adventist Church	Hinsdale
September 10	Christ Hospital	Oak Lawn
September 11	Daley Center	Chicago
September 17	St. Therese Hospital	Waukegan
October 8	Lake Forest Hospital	Lake Forest
October 9	Daley Center	Chicago
October 29	Lutheran General Hospital	Park Ridge
November 5	YWCA	Rockford
November 5	Christ Hospital	Oak Lawn
November 6	Daley Center	Chicago
November 11	Seventh Day Adventist Church	Hinsdale
December 4	Daley Center	Chicago

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

September

Acute Care

Initial Management of the Acutely Ill Patient

For: MD's. Dinned/lecture, Sept. 25, 6:00 p.m., Highland Park. Speaker: Frank J. Baker, II, MD. Sponsor: Highland Park Hospital, 718 Glenview Ave., Highland Park 60035. Reg. deadline: 9/14. Fee: \$10. Reg. limit: 60. Credit: AMA Category 1, 1 hour. Contact: Arnold Goldstein, MD. Phone: 312/432-8000 x 4000.

Family Medicine

Sixth Annual Family Practice Review Conference

For: M.D.'s. Symposium, Sept. 20-21, Holiday Inn East, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$125. Credit: AMA Category 1, 14 hours; AAFP Prescribed, 14 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Post-Operative Complications

For: MD's. Symposium, Sept. 27, 9:00 a.m., East St. Louis. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Fluid & Electrolytes & Hyperalbuminemia

For: MD's. Symposium, Sept. 12, 6:00 p.m., Hyland. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Office Dermatology

For: MD's. Symposium, Sept. 13, 1:00 p.m., Pinckneyville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Alcoholism

For: MD's. Symposium, Sept. 13, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$29. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Inflammatory Bowel Disease

For: MD's. Symposium, Sept. 6, 7:00 p.m., Mt. Vernon. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Recent Advances in Diagnostic Techniques for Medical Practice

For: MD's. Seminar, Sept. 15, 1:00 p.m., Chicago. Speaker: Bonn Kong, MD, FACP. Sponsor: Korean Medical Association of America; Mt. Sinai Hospital Medical Center, 15th & California Ave., Chicago 60608. Reg. deadline: 9/1. Fee: \$20. Reg. limit: none. Credit: AMA Category 1, 4½ hours. Contact: James Shoffer, ScD. Phone: 312/542-2563.

Occupational Medicine

Occupational Medicine—On the Horizons

For: MD's, nurses, assistants. Seminar, Sept. 7-8, Columbus, IN. Sponsor: Central States Occupational Medical Assn., 119 Shabbona Drive, Park Forest, IL 60466. Cosponsors: American Occupational Medical Assn. Fee: yes. Reg. limit: none. Credit: AMA Category 1, 8 hours; AAFP Elective, 8 hours. Contact: Rita Packer.

Ophthalmology & Otolaryngology

Fall Meeting

For: Specialists in Oph. & Oto. Lectures, Sept. 15-16, Freeport. Sponsor: Illinois Society of Ophthalmology & Otolaryngology, 101 West North St., Danville, IL 61832. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: A. Reese Motteson, MD. Phone: 217-446-6410.

Pediatrics

Infant Nutrition

For: Pediatricians, GP's, FP's. National TV broadcast, Sept. 26, 3:00 p.m., Pick-Congress Hotel, Chicago. Sponsor: University of Iowa College of Medicine, c/o Health Learning Systems, Inc., P O Box 4243, New York, NY 10017. Cosponsors: National Heart, Lung & Blood Institute; National Kidney Foundation, American Heart Association. Reg. deadline: none. Fee: none. Reg. limit: none. Credit: AMA Category 1, 3 hours; AOA, Category 2-D, 3 hours; AAFP Prescribed, 3 hours; approved by Committee on Nutrition, American Academy of Pediatrics.

Pediatrics

Downstate Illinois Pediatric Society

For: Pediatricians, FP's. Course, Sept. 8-9, Ramada Convention Center, Champaign. Speaker: Harold Martin. Sponsor: Carle Foundation Hospital, 611 W. Park Ave., Urbana 61801. Cosponsors: Downstate Illinois Pediatric Society, University of Illinois, Illinois Chapter American Academy of Pediatrics. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 6 hours. Contact: Terry Hatch, MD. Phone: 217/337-3022.

Pediatric Anesthesia

Pediatric Anesthesia Update

For: Pediatricians. Seminar, Sept. 8, Round Barn Bonquet Centre, Champaign. Sponsor: U of I College of Medicine, 505 E. Green St., Champaign 61820. Fee: \$25, MD; \$15, CRNA's & RN's; \$10, residents. Contact: Barbara LeGrand. Phone: 217/333-8145.

October

Alcoholism

Seminar Series on Alcohol and Drug Abuse

For: GP's, Internists, Psychiatrists. Seminar, Oct. 12-13, Sheraton Plaza, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Reg. limit: 150. Fee: \$50. Credit: AMA Category 1, 12 hours. Contact: Sue Korieneck. Phone: 312/996-8025.

Cardiac Rehabilitation

Total Cardiac Rehabilitation Process

For: MD's. Workshop, Oct. 8-19, La Crosse, WI. Sponsor: Exercise Program—University of WI—La Crosse, Workshop Unit, Mitchell Hall, La Crosse, WI 54601. Cosponsors: Gundersen Clinic, Ltd., International Medical Education Corp., La Crosse Lutheran Hospital, Skemp Grandview Clinic, St. Francis Hospital. Fee: \$350. Reg. limit: 40. Credit: AAFP Prescribed, 43 hours; CEARP, 43 hours; Iowa P.T. Examiners, 35 hours. Contact: Philip Wilson. Phone: 608/785-8687.

Dermatology

Primary Care Dermatology

For: Primary Care Dermatologists. Course, Oct. 5-7, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Fee: \$175. Reg. limit: none. Credit: AMA Category 1, 12 hours. Contact: Patricia McClure. Phone: 312/649-8533.

Emergency Medicine

Eighth Annual Emergency Care Symposium/Cardio-Pulmonary Emergencies

For: MD's. Lecture, Oct. 20, Lafayette, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Financial Planning

Financial Planning for the Future

For: MD's. Lecture, Oct. 19-20, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$82.50. Credit: AMA Category 1, 12 hours. Contact: John Roscoe. Phone: 317/264-8353.

Clinical & Laboratory Diagnosis of Hemorrhagic & Thrombotic Disorders

For: Internists, Hematologists. Lecture, Oct. 19 (2 days), Chicago. Speaker: Hou Kwaan, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Fee: \$150. Reg. limit: 100. Credit: AMA Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Medical Photography

Fifth Annual Medical Photography Workshop

For: MD's. Workshop, Oct. 27, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 7 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Problems and Concepts of Care for Terminally Ill

For: MD's, RN's, hospital administrators. Course, Oct. 19, Continental Plaza Hotel, Chicago. Sponsor: Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60604. Credit: AMA Category 1, 8 hours; AOA, 8 hours. Contact: Louis Kuhn. Phone: 312/944-5144.

Medicine

Seventh Annual Weber Clinic Medical Conference

For: MD's. Conference, Oct. 27, 12:30 p.m., Olney. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Immunology

For: MD's. Symposium, Oct. 23, 7:00 p.m., Vandalia. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Common Lower Gastrointestinal Tract Disorders

For: MD's. Symposium, Oct. 4, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Diabetes and Metabolic Disease

For: MD's. Symposium, Oct. 6-7, 1:00 p.m., Robinson. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 10 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Nephrology

Nephrology Update

For: primary care physicians. Lecture/panel, Oct. 5, Terre Haute, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Neuro-Ophthalmology

Clinical Neuro-Ophthalmology

For: Ophthalmologists, Neurologists, Neuro-Surgeons. Lecture, Oct. 18, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Surgery

Head & Neck Cancer: New Development in Diagnosis & Treatment

For: MD's. Symposium, Oct. 19-20, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Surgery & Medicine

Infectious Disease

For: MD's. Symposium, Oct. 10, 8:00 a.m., Holiday Inn East, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 8 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

November

Family Medicine

Standards of Eye Care for the Primary Physician

For: General Practice, Emergency Medicine. 2-day seminar, Nov. 29-30, Chicago. Sponsor: U of I at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: none. Fee: \$150. Credit: AMA Category 1, 14 hours. Contact: Jane Whitener. Phone: 312/996-8025.

Family Medicine

Management of the Acute Cardiac Patient

For: FP's. Lecture, Nov. 28 (3 days), Chicago. Speaker: Kenneth Rosen, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$175. Reg. limit: 75. Credit: AMA Category 1, 21 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Hypertension

105th Annual Meeting of Southern Illinois Medical Association

For: MD's. Course/lectures, Nov. 8, 8:00 a.m., Fischer's Restaurant, Belleville. Sponsor: Southern Illinois Medical Association. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Dale Rosenberg, MD, Suite 3-E, 6401 W. Main St., Belleville 62223. Phone: 618/398-5600.

Medicine

Advances in Medicine

For: Internists. Lecture, Nov. 5 (5 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Neurology

Basic Neurological Examination

For: MD's. Symposium, Nov. 2, 11:15 a.m., Oak Park. Speaker: Jordan Topel, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

How to Use the Mental Status Examination

For: MD's. Symposium, Nov. 9, 11:15 a.m., Oak Park. Speaker: Ralph Pagano, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

Alzheimer's Disease—Diagnosis and Treatment

For: MD's. Symposium, Nov. 16, 11:15 a.m., Oak Park. Speaker: Bernard Kirk, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

The Comatose Patient—Diagnosis and Treatment

For: MD's. Symposium, Nov. 30, 11:15 a.m., Oak Park. Speaker: L. L. Yarzagaray, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Obstetrics

Evaluation & Management of the Infertile Couple

For: GP's, Obstetricians. Lecture, Nov. 14, 1:30 p.m., Chicago. Speaker: George Marulis, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Otolaryngology

7th Course in Clinical Neurotology

For: Otolaryngologists. 4-day seminar, Nov. 5-8, Chicago. Sponsor: U of I at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: none. Fee: \$300. Credit: AMA Category 1, 28 hours. Contact: Jane Whitener. Phone: 312/996-8025.

Psychiatry

Management of Sex Problems in Medical Practice

For: MD's, spouses. Nov. 17-19, Water Tower Hyatt House, Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Loyola University, Dept. of Psychiatry, 2160 S. First Ave., Maywood 60153. Fee: \$160, MD; \$110, spouse. Credit: AMA Category 1, 20 hours. Contact: Dept. of Psychiatry. Phone: 312/531-3272.

Concerned Over High Cost of CME?

Growth in CME requirements over the country has increased *availability* of CME opportunities, with two consequences: (1) You've lots of choice, and (2) tuition fees by and large have *not* risen significantly. For details, request "How to Get the Most for Your C.M.E. Dollar."

Two ICCME handbooks offer further suggestions on how to keep down the cost of CME: *Your Personal Learning Plan* and *How to Start a CME Program*.

All are free to Illinois physicians and CME sponsors; just call—or write the titles you want on your prescription form and mail to—

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(USPS 258-160)

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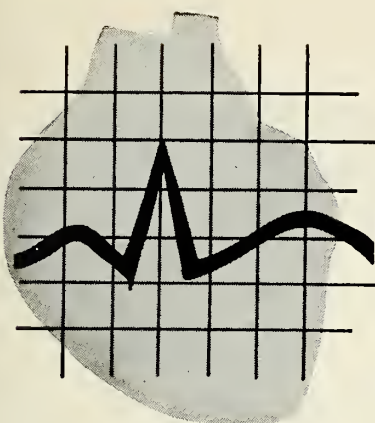
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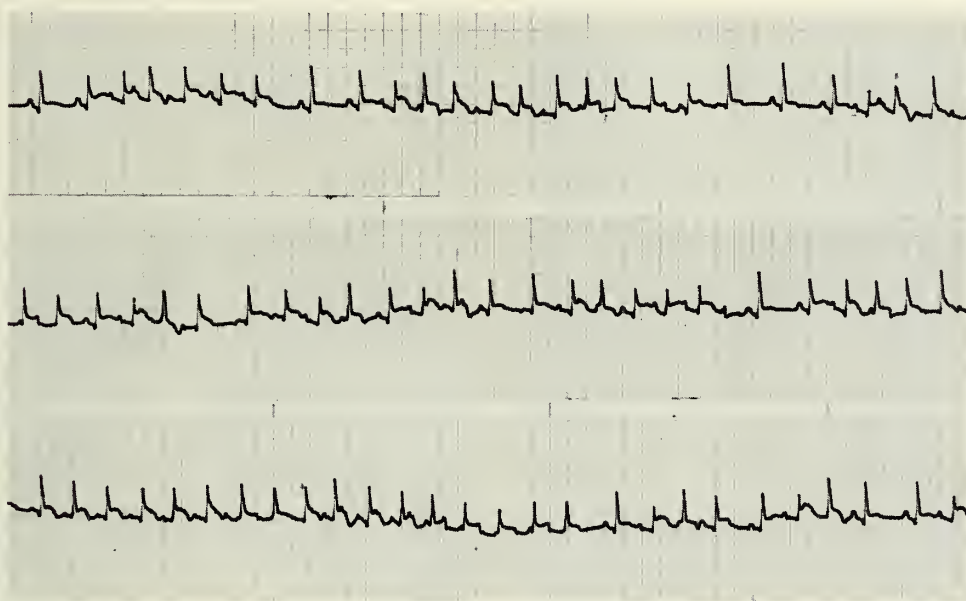
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ekg of the month

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Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This patient, a sixty-three year old man, presented to the emergency service. He gave a history of three hours of severe chest pains accompanied by nausea and diaphoresis. The man appeared ashen, diaphoretic, and had a blood pressure of 110/70mmHg. His lungs were clear and there was a ventricular gallop (S_3) at the apex on examination of the heart. The 12-lead ECG shows an acute inferior wall myocardial infarction. He was admitted to the coronary care unit. The next day this rhythm strip was recorded.



Questions:

- The ECG rhythm strip shows:**
 - Multifocal atrial tachycardia.
 - Atrial flutter with 2:1 atrioventricular block.
 - ST segment deviation, or a current of injury.
 - All of the above.
- The following statement(s) is/are true:**
 - Supraventricular tachycardias in the presence of an acute myocardial infarction have an incidence up to 16%.
 - Supraventricular tachycardias associated with an acute myocardial infarction lead one to suspect an atrial infarction.
 - The etiology of the tachycardia may also be cardiogenic shock, congestive heart failure, pericarditis, as well as sinus node ischemia.
 - Systemic embolization has been reported in this clinical setting.
 - All of the above.

(Continued on page 196)

KENNEDY'S NEW HEALTH PROPOSAL MORE SLOGAN THAN REALITY

As their National Health Insurance plan of the year, Senator Ted Kennedy and his helpmates have built a bright-eyed new statue with the same old clay.

The new "Health Care for All Americans" bill differs from his old "Health Security" bill in various particulars but not in basic materials.

Again the public would save on health bills by paying substantially more in tax bills. By the proponents' own estimates, the new federal costs would be \$30 billion in 1983, the year targeted for implementation. And as we know, the costs of federal programs—especially social ones—have a facility for growing.

Again there would be the heavy hand of government intervention and regulation.

But instead of being squeezed under, as in the Health Security bill, it appears private health insurers would be allowed a role of subordination. Government would regulate them and preside over negotiations on their premiums and on physician and hospital payments, and no company would be "at risk" in the true insurance sense.

In the spirit of the old bill, there would be a built-in stress and strain between health care promises and economic prohibitions.

On the one hand, the measure would guarantee comprehensive health insurance coverage to every American at all times, amplify Medicare coverage (with no deductibles or co-insurance), reform Medicaid (eliminating the means test), and so forth.

On the other hand, the program would be subject to a national budget, whereby health expenditures would be strictly limited by state and regional allocations. Providers would have to furnish all services within the limit.

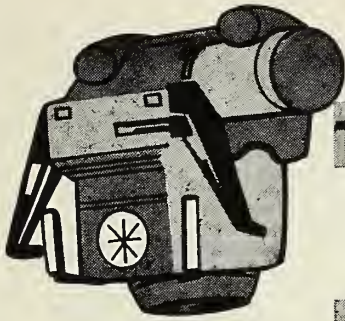
If funds run out before the end of a budget period, would providers be expected to subsidize health services? Would budget restraints and negotiation of insurance premiums and provider payments invite government rationing of care?

Those are among the grim but realistic questions to be raised as Mr. Kennedy and his supporters try to supply all the answers.

Certainly we all want answers—sound answers—to present gaps and shortcomings in health protection. In the words of AMA Executive Vice President James H. Sammons, M.D., "The AMA continues to believe that consumer choice, private insurance, and limited government regulation should be at the heart of our health care system."

"Medicine again faces a renewed responsibility to speak out on the major legislative proposals dealing with health care and to share our concerns with the Congress and our fellow citizens."

AMA



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Richard A. Cooper, M.D., a clinical associate professor of radiology at the Loyola University Medical Center in Maywood.

The patient is a 32-year-old male. He is healthy and asymptomatic, and had a barium enema as a routine pre-operative study prior to a right inguinal hernia repair.



Figure 1

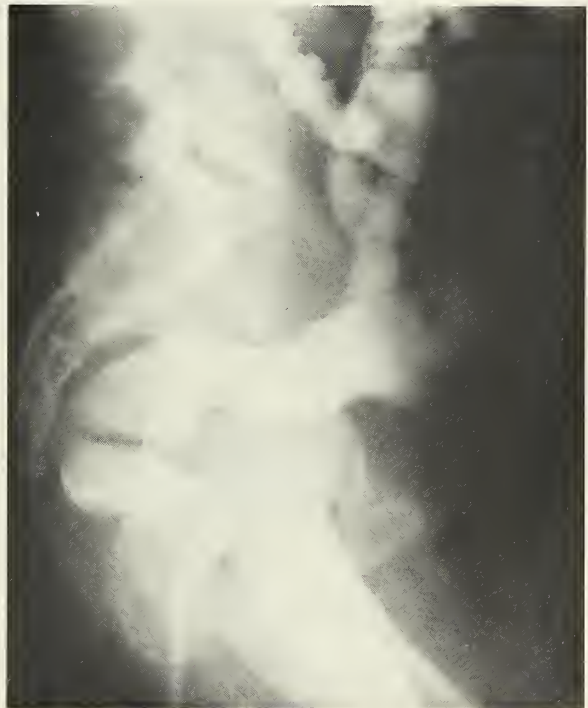


Figure 2

What's Your Diagnosis?

- A) ectopic kidney
- B) ulcerative colitis
- C) normal exam
- D) hematoma

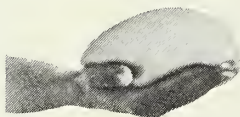
(Continued on page 190)



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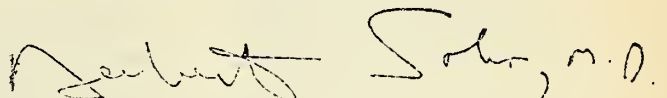
Our lives and our economy are increasingly caught up in an ever-constricting web of laws and regulations that threaten to bring our vaunted free-enterprise system to its knees unless we act.

Massachusetts Senator Edward Kennedy
June 14, 1979

There are those of our readers who might be surprised at my choice of the above quotation as the key to this month's column. However, I believe firmly that Senator Kennedy is right.* As medical care providers, a greater and greater percentage of our time is spent in complying with the multitude of federal, state and local regulations which govern our lives, both as professionals and as private citizens. Some of us bemoan the fact that our lives seem not to be under our own control anymore.

IMPAC believes that we can control our lives and our practices -- through political action -- through involvement in the political process, both locally and on the national level. One of our goals is to encourage physician candidates and physician activists to become part of the process. And we are looking for your help. Are you interested in becoming a candidate for legislative office? Do you know of someone who is? If so, contact IMPAC so that we can evaluate your candidacy and suggest ways you can maximize your effectiveness as a candidate or as a campaign volunteer. Are you interested in the political process but don't know how to get actively involved? Again, contact IMPAC and we'll put you in touch with your physician counterparts in your own area.

IMPAC is more than a candidate support organization. We also want to assist physicians who'd like to get involved. Interested in more information? Write: IMPAC, 55 E. Monroe, Chicago, Illinois 60603



Herbert Sohn, M.D., Chairman

* At least his words in this instance echo a sentiment I believe.

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

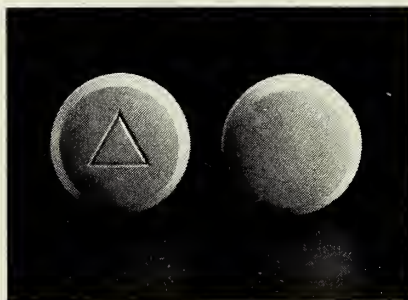
MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

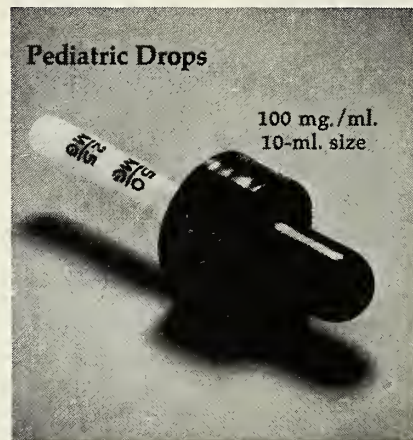
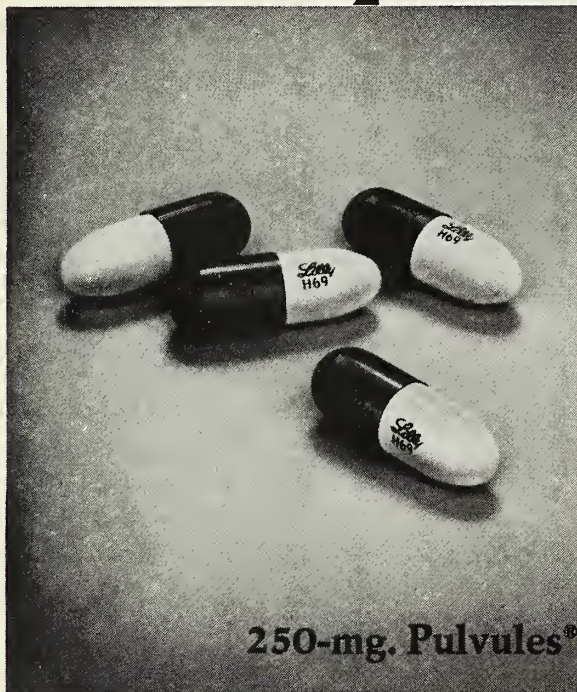
The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



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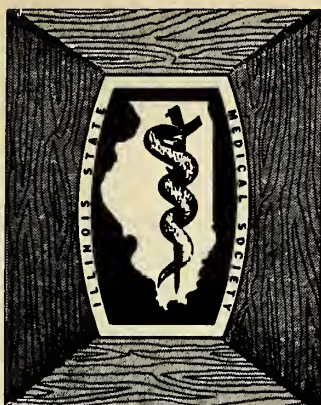
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IMJ

Illinois Medical Journal

Vol. 156, No. 3, September, 1979

A Unified Approach To Management Of Genitourinary Trauma

SALVADOR ZAMORA-MUNOZ, M.D., ROOHOLLAH SHARIFI, M.D., IRVING M. BUSH, M.D., S. KRISHNA M. TALLURI, M.D., BALAKRISHNA SUNDAR, M.D., RICHARD J. ABLIN, PH.D., AND PATRICK D. GUINAN, M.D./CHICAGO

During the years 1960 through 1975, 3,336 genitourinary injuries (Table 1) were treated in the trauma unit, admitting room, urologic clinics, and wards of Cook County Hospital. This report is a summary of urologic trauma management principles that have evolved from the experience

gained in treating these patients. This paper is not meant to be dogmatic but rather a distillation of management philosophy resulting from this large experience.

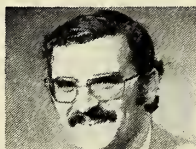
All patients have individualized disease, and the trauma patient even more so, because trauma patients often have injuries of several organ systems. An attempt has been made, by the use of flow charts, to simplify the conceptual approach to GU trauma. Because of the diverse nature of the traumatic event, simplified flow charts have even more limitations than generalizations applied to other diseases. The Cook County Hospital experience is that of one institution, albeit one with more trauma than many others, and these management guidelines are offered as a potential aid to other urologists and trained surgeons who may not have experienced this volume of trauma.

Materials

Of the 3,336 patients, 731 had incomplete records and were not included in this report. The remaining 2,605 patients comprised 1,425 individuals with upper urinary tract trauma and 1,180 with lower tract injuries. Of the 1,425 upper urinary tract injuries, 1,359 involved the kidney and 66 involved the ureter. The majority (868) of these renal injuries were blunt. There were 491 penetrating injuries.

The management of the patients with renal trauma followed conventional guidelines. Most patients with blunt renal injuries were treated

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TABLE I
GENITOURINARY TRAUMA AT
COOK COUNTY HOSPITAL 1960-1975

INCOMPLETE RECORDS	731
ADEQUATE RECORDS	2605
I. UPPER URINARY TRACT	
KIDNEY - BLUNT	868
KIDNEY - PENETRATING	491
URETER AND RENAL PELVIS	66
TOTAL	1425
2. LOWER URINARY TRACT	
BLADDER	594
PROSTATE AND URETHRA	312
PENIS, SCROTUM & TESTIS	273
RECTUM	1
TOTAL	1180
TOTAL	3336

conservatively, and most individuals with penetrating trauma were managed operatively. Only 12% of the patients with blunt injuries had a renal exploration and there was a 29% nephrectomy rate in those patients. On the other hand, 82% of the patients with penetrating injuries were explored with a 23% nephrectomy rate. The lower nephrectomy rate in those patients with penetrating injuries would suggest that surgery can indeed lead to kidney salvage and has encouraged a more aggressive management of renal trauma.

Trauma Unit

All patients coming to Cook County Hospital with significant trauma enter the hospital through the Admitting Room and are referred to Trauma Unit. Once in the Trauma Unit, an initial assessment of the injury is made. The work-up and management of the patient depends upon the magnitude of injury. For a patient with potentially significant injury, work-up and treatment proceed simultaneously. A history and physical examination are obtained, as well as blood for complete blood count, urine for urinalysis and culture, and X-rays (including four views of the abdomen and appropriate bone films). At the same time that an IV is begun, a type and cross match are obtained, a central venous pressure catheter is inserted, and if indicated, a Foley catheter is placed in the bladder. If the patient has multiple system injuries, all indicated

consults are obtained.

Urologic Trauma

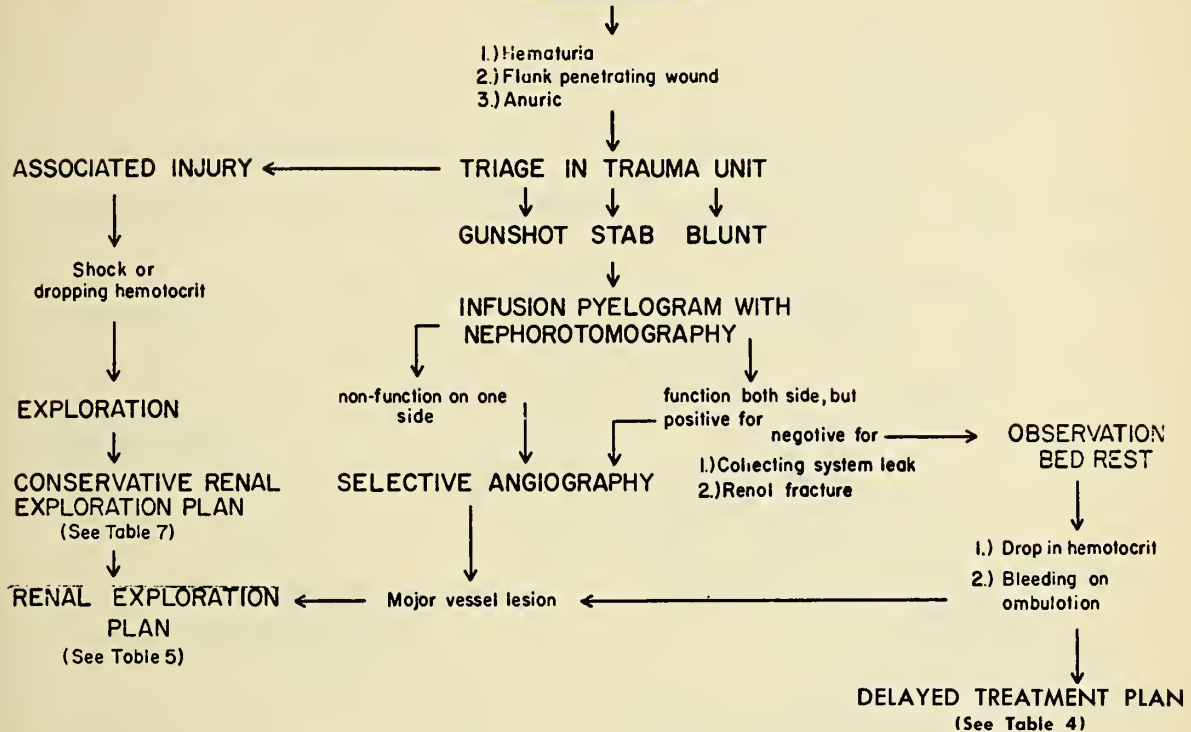
If it is suspected that the patient has a genitourinary injury the Division of Urology is consulted. The Urology work-up continues parallel to the management of other injuries. This is essential because 60% of patients with penetrating renal trauma have associated abdominal injuries and 15% of these same patients will have an associated chest injury. The most serious injury takes precedence in patient management. Patients who are stable are generally treated more conservatively while patients who are unstable are often managed surgically. Associated injuries often dictate surgical exploration and aid in the assessment of a urologic injury, since the abdomen and retroperitoneum can be directly examined during laparotomy.

Renal Injury

When the work-up has revealed a renal injury from either a gunshot, stab, or blunt trauma, an infusion intravenous pyelogram (IVP) is obtained (Table 2). Absence of function on either side, evidence of collecting system leak, or significant renal fracture indicate selective renal angiography.¹ A gunshot wound, injured vessel, or a dropping hematocrit (need for 2 units of blood) are indications for operative intervention.²⁻⁴ Absence of the above suggests observation.⁵ The presence or absence of gross hematuria does not always correlate with the need for exploration or extent of injury.

With radiologic evidence of active bleeding or a deteriorating clinical condition, renal exploration is mandatory^{2,3,6} (Table 3). The pedicle is isolated first and control of the artery and vein is obtained.^{7,8} If there is complete disruption of the kidney a nephrectomy is performed.^{2,3,6} If the vein and artery are injured and the remainder of the kidney is intact the vessels are repaired.^{5,9,10} In upper pole, lower pole and lateral parenchymal injuries the devitalized tissue is debided, the bleeding vessels ligated, the collecting system sutured and the capsule is closed over fat.^{4,8,11}

If there is question of a renal injury and the abdomen is to be explored for some other reason the Conservative Renal Exploration Protocol, which includes possible use of partial nephrectomy, is employed (Table 4).^{2,6,14,15} The retroperitoneum is examined prior to repair of non-urologic injuries. After repair of these other injuries, if the renal status has not progressed,

TABLE 2**RENAL INJURY**

Gerota's fascia is not opened. If there is a question about the extent of the renal injury, an intra-operative arteriogram can be performed.

If the diagnosis is renal contusion but without evidence of significant injury on IVP or angiography, and the patient is stable, he is maintained at bedrest until the hematuria clears and then carefully observed for 24 hours after ambulation.

Ureteral And Renal Pelvis Injury

Ureteral and renal pelvic injuries are worked up and diagnosed much like renal injuries with an infusion pyelogram and nephrotomograms. Retrograde pyelography is often beneficial, particularly in iatrogenic injuries which usually occur in the lower 1/3 of the ureter.¹⁶ Retrograde pyelography is performed as the last test in the work-up or if a management change is contemplated.

Loss of less than 1/3 the ureteral diameter requires only debridement and stenting. Loss of greater than 1/3 the diameter requires end to end anastomosis with proximal stenting.^{4,12,15} Loss of over 3-4cm of length is best

managed by transureteroureterostomy, bowel interposition or possibly inferior nephropexy.¹⁶⁻¹⁸ In unusual cases cutaneous ureterostomy or even nephrectomy may be necessary to save the patient's life.

Bladder Injury

Bladder injuries are best diagnosed by cystogram (Table 5). Although an infusion pyelogram first will better demonstrate ureteral injuries, the cystogram should be performed initially. Thus, a bladder injury can be diagnosed more accurately and rapidly.¹⁹ Perforations of the bladder are best managed with cystotomy, although extroperitoneal perforations may be treated by catheter drainage, particularly in a female.^{4,15,19} In closing bladder penetrating lesions it is best to close both the peritoneum as well as the bladder mucosa. Also, look for and close the second hole in the bladder often seen in penetrating wounds.^{4,19} More recently, use of an illuminating catheter has been a help in demonstrating ureteral defects.

TABLE 3

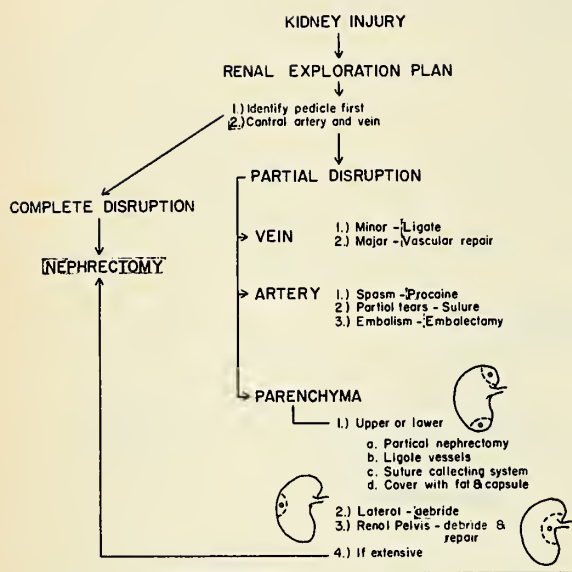


TABLE 4
KIDNEY INJURY
DELAYED TREATMENT PLAN

- 1.) REPEAT HEMATOCRIT q 1h for 6 hours
then q 4-6h for 24 hours
then qdx 7 days
- 2.) BED REST until gross hematuria stops and blood count stabilizes (5-10 days).
- 3.) USE OF RETROGRADE PYELOGRAMS ONLY WHEN:
 1. suspicious of urinary leak or disruption
 2. as lost diagnostic test
 3. if it will change course of therapy
- 4.) FOLLOW-UP IVP 10 days - 2 weeks then 3 months and 6 months
- 5.) RENAL SCAN can be helpful in follow up.
- 6.) RECURRENCE OF BLEEDING ON AMBULATION repeat IVP and arteriogram. Drop in hematocrit or bleeding site identified is indication for exploration and nephrectomy (partial difficult but can be done).

TABLE 5

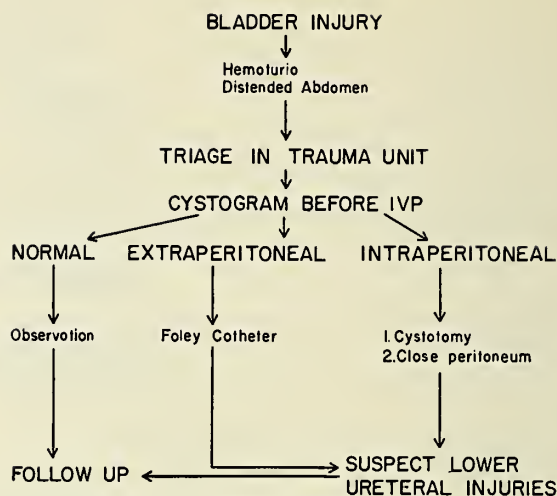
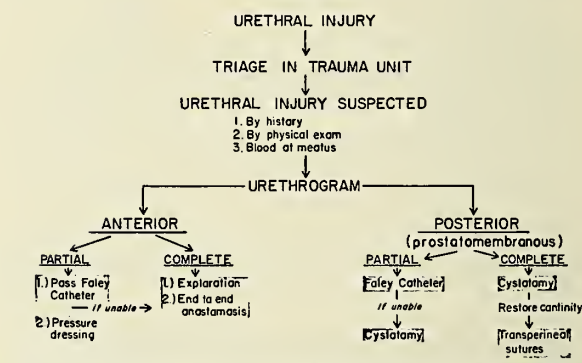


TABLE 6



Urethral Injury

If the history suggests a urethral injury and the patient's condition permits, a urethrogram should be obtained (Table 6). An attempt to insert a Foley catheter should be made to restore the continuity of the urethra. If catheterization is unsuccessful cystostomy should be performed.^{20,22} If antegrade urethral continuity can be effected at this time it should be done.^{20,21,23} If the patient has only a lower tract injury it may be possible to primarily repair the urethra perineally or to possibly split the symphysis for

better exposure in cases of membranous rupture.^{24,26} If there is a complete transection of the urethra with a high riding prostate on physical examination, an attempt to bring the prostate into the pelvis with transperineal sutures should be made.^{20,22,24,27}

Scrotal, Testicular, And Penile Injury

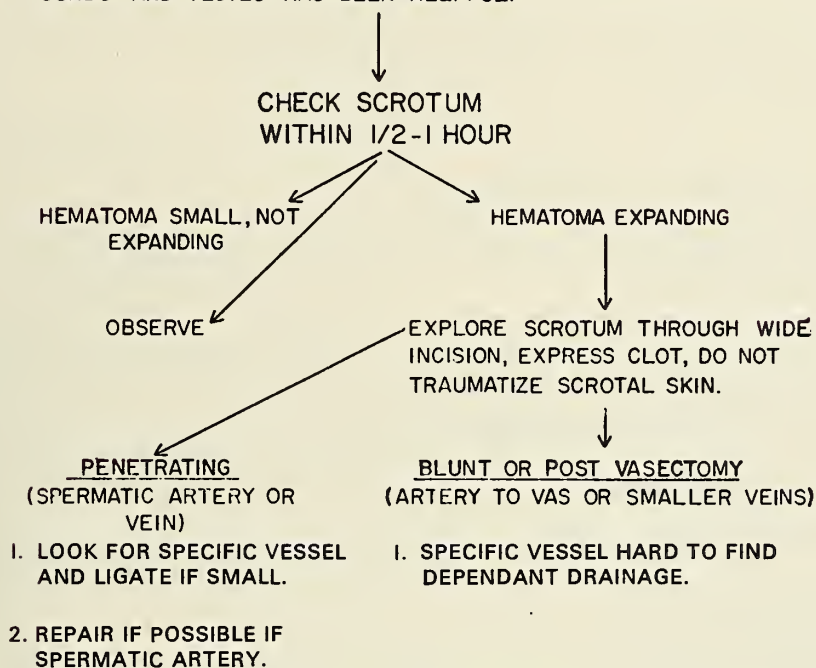
Hematomas of the scrotum that are small and not expanding are observed; large or expanding hematomas are explored (Table 7). Debridement of the scrotum is performed in penetrating injuries. An effort should be made to conserve all genital tissue, even skin, wherever possible. Doppler evaluation of the integrity of the spermatic artery has recently been found to be helpful.

Because of testicular mobility, rupture is somewhat unusual. If the testicle is ruptured, protrud-

TABLE 7

SCROTUM

1. MEASURE SIZE OF TESTICLES AND SCROTUM WITH TAPE MEASURE OR CALIPERS IN SEVERAL DIRECTIONS.
2. OBTAIN PERMISSION FOR POSSIBLE SURGICAL REMOVAL OF TESTICLE OR NECESSITY TO LIGATE ARTERY OR VEIN.
3. PREPARE FOR SURGICAL EXPLORATION.
4. MORE RECENTLY, DOPPLER READING OF BOTH SPERMATIC CORDS AND TESTES HAS BEEN HELPFUL.



ing tubules should be trimmed, the tunica debrided and closed with running suture.

An attempt should be made to reanastomose amputated penises. Penile avulsions should be allowed to demarcate with minimal initial debridement in an effort to conserve as much genital tissue as possible. However, debride human bites vigorously and do not suture.

Wide debridement of all infected and necrotic scrotal tissue can safely be performed because the scrotum has a remarkable regeneration capacity. While the scrotum is regenerating, the testicles can safely be packed in sterile saline dressings.

Conclusion

Victims of genitourinary trauma will present to every hospital and all primary care physicians, and most specialists will occasionally be called upon to assist in the evaluation and treatment of these patients. It behooves all practitioners to be aware of the basic management principles of urologic trauma.

Individuals with a history, or a physical examination suggesting a significant upper urinary tract injury should have an intravenous pyelogram. Evidence of blood loss and a non-visualized kidney prompts a renal angiogram, if available.

Non-perfusion of the renal unit, extravasation of contrast beyond the confines of the collecting system, and/or a dropping hematuria, might suggest a renal exploration, and if the kidney is not salvagable, a nephrectomy.

Suspect lower urinary tract trauma necessitates a cystogram, and possibly a urethrogram if there is urethral injury. Extravasation of contrast requires prompt surgical exploration and repair to restore the integrity of the urinary tract. Extensive or long standing injury is best managed by urinary diversion by cystostomy. Injuries of the external genitalia should be managed by debridement and primary closing. ◀

Acknowledgement

Supported by a grant from the Hektoen Institute for Medical Research RR 05524-15.

References

A complete list of references for "A Unified Approach to Management of Genitourinary Trauma," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Obituaries

***Blumenthal, Helmut**, Chicago, died July 18, 1979, at the age of 73. Dr. Blumenthal was a 1932 graduate of Freidrich-Wilhelms University in Germany.

****Deutsch, Jack B.**, Chicago, died July 23, 1979, at the age of 79. Dr. Deutsch was a 1926 graduate of the Loyola University Stritch School of Medicine. He also was a former president of the medical staff at St. Anne's Hospital.

****Fentress, Thomas L.**, Winnetka, died July 18, 1979 at the age of 75. Dr. Fentress was a 1928 graduate of the Harvard Medical School in Boston.

***Fried, Samuel L.**, Fox Lake, died August 3, 1979 at the age of 71. Dr. Fried was a 1934 graduate of Chicago Medical School.

***Kaiser, Lloyd F.**, Champaign, died July 19, 1979 at the age of 73. Dr. Kaiser was a 1931 graduate from Washington University.

****Lebensohn, James E.**, Chicago, died July 31, 1979, at the age of 86. Dr. Lebensohn was a 1917 graduate of Rush Medical College. He had served on the staffs of Cook County and Mt. Sinai Hospitals.

***Lockner, Harold Livingston**, Chatsworth, died July 3, 1979, at the age of 73. Dr. Lockner was a 1933 graduate of Northwestern University Medical School.

Marten, Sue, Springfield, died July 17, 1979, at the age of 41. Dr. Marten was a 1962 graduate of the University of Missouri.

***Presley, Sophie J.**, Chicago, died July 4, 1979, at the age of 56. Dr. Presley was a 1945 graduate of the University of Illinois.

***Seegall, Harold F.**, Chicago, died August 3, 1979, at the age of 70. Dr. Seegall was a 1936 graduate of Loyola University Stritch School of Medicine.

Stanton, John William, Chicago, died May 24, 1979, at the age of 95. Dr. Stanton was a 1907 graduate from Northwestern University Medical School.

***Toman, Andrew J.**, Riverside, died August 2, 1979, at the age of 74. Dr. Toman was a 1931 graduate of the University of Illinois. He held the post of health director of Berwyn from 1957 to 1960, and served as Cook County Coroner for 16 years.

****Wellmerling, Hermann William**, Bloomington, died July 26, 1979, at the age of 92. Dr. Wellmerling was a 1921 graduate from the Washington University.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club

Macrocysts of the Parathyroids

BY RUSSELL G. KOOY, M.D. AND EDWARD V. GHISLANDI, M.D., F.A.C.S./CHICAGO

Sandstrom¹ first described the parathyroid glands in 1880. He noted several examples of "quite small cysts hardly as large as a pin's head, the inner walls of which are coated with a very thin endothelium-like layer of cells . . ." Also observed by Sandstrom was one case of a macrocyst about the size of a nut, but microscopic examination was not done due to decomposition of the specimen. Therefore, documentation of the cyst origin was not accomplished. Credit is usually given to Gloris² in 1905 for describing the first macrocyst of the parathyroids.

Any cystic structure of the neck or mediastinum associated with parathyroid tissue has been labeled at one time or another as a parathyroid cyst. Maxwell,³ in 1952, defined parathyroid cysts as having: (1) fields of typical parathyroid cells in the cyst wall; (2) a lining of cuboidal or columnar epithelium; (3) a location in a

position corresponding to that of a parathyroid gland.

Furuya and Baba⁴ added that parathyroid tissue must be present outside of the fibrous capsule of the cyst. The present authors wish to clarify the definition by stating that the internal lining of the cyst wall must be *solely* by a single layer of cuboidal or columnar epithelium. This statement will help differentiate between cystic degeneration of an adenoma and a true parathyroid cyst.

Case Report

A 31-year-old man presented with an asymptomatic mass on the right side of his neck. The mass was non tender and had not enlarged since its discovery one year previously. The patient denied hoarseness, dysphagia, or symptoms of hyperthyroidism or hyperparathyroidism.

Physical examination revealed a healthy-appearing 31 year old man: pulse 80, respiration 20, blood pressure 130/70. There was a firm 3x3cm mass in the right side of the neck, which moved vertically on deglutination. No bruit over the mass was heard and the trachea was not deviated. Indirect laryngoscopy was normal. Remaining physical examination was unremarkable. Laboratory evaluation by SMA-12, electrolytes, blood count and urine analysis was normal; serum calcium and phosphorus were normal. T3 and T4 were reported as 31.9% relative uptake (N=25-35) and 8.0 mcgms/dilution (N=5.4-13.0) respectively. EKG and chest X-ray were normal. Thyroid scan revealed

a 1.5cm cold area in the right lower lobe of the thyroid.

A B-mode ultrasound study of the neck was performed and was interpreted as demonstrating a solid mass, although a cystic component could not be excluded.

With a preoperative diagnosis of non-toxic thyroid nodule, the patient was taken to the operating room. Exploration of the neck revealed a 3x3cm cyst adjacent to the right lower lobe of the thyroid. The cyst had slightly displaced the thyroid anteriorly and medially. It was easily dissected free. No further abnormalities of the thyroid or parathyroids were identified. The patient's postoperative course was unremarkable, and repeat serum calcium and phosphorus levels found normal.

The pathologist described the specimen as a thin walled oval shaped cyst, measuring 4x3x3cm. The cyst was translucent and contained clear pinkish fluid. Microscopically, it was lined by flattened uniform epithelial cells. The connective tissue capsule contained small aggregates of parathyroid cells. (Figures 1 and 2)

Clinical Presentation

Most parathyroid cysts present themselves as asymptomatic masses in the neck. Laboratory values for thyroid function are normal. Thyroid scan usually reveals a "cold" area. If symptomatic, it is usually caused by pressure on adjacent structures: trachea, esophagus, or recurrent nerve. Occasionally, the cyst is identified as a mediastinal mass on chest X-ray. Rarely, the cyst is associated with hyperpara-

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EDWARD V. GHISLANDI, M.D., is a board certified surgeon and instructor in the department of surgery at Northwestern University Medical School. Dr. Ghislandi is also on the staffs of Calumbus-Cunea-Cabrini Medical Center and St. Frances X. Cabrini Hospital in Chicago.

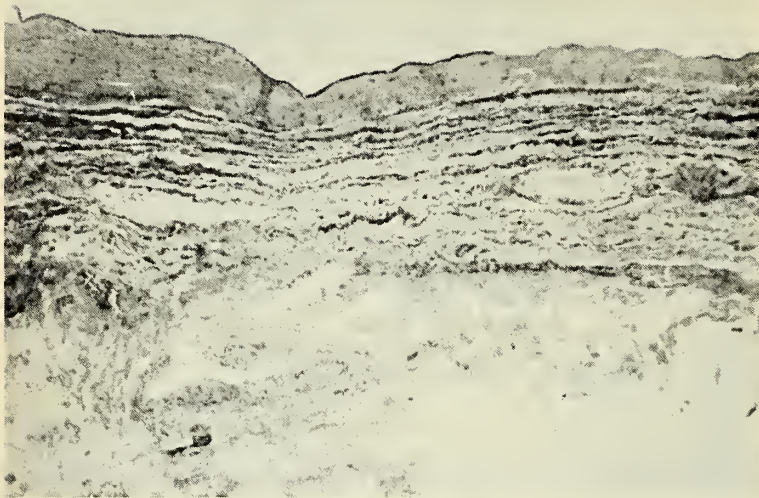


Figure 1

Note the thick fibrous wall with the internal lining of flattened uniform epithelium, focally denuded in some areas.

thyroidism. Simple excision of the cyst is the preferred treatment as adhesions to surrounding structures were easily freed in most cases.

Parathyroid Cysts: Theories of Origin

Four major theories of origin have been proposed in the literature: (1) coalescence of microcysts; (2) retention cysts; (3) degeneration of adenomas; and (4) embryonic origin.

Coalescence of Microcysts

Castleman and Mallory⁵ found microcysts of the parathyroids in 50% of autopsy cases. Black and Watts⁶ reported finding microcysts in 84% of cases with 42% being greater than 100u. Gilmour reported that cystic vesicles of the parathyroid were more common in the inferior glands, which correlates well with the location of macrocysts. The three reported cases of multiloculated cysts could well be explained by the coalescence theory.^{2,8,9}

Retention Cysts

Selye,¹⁰ in 1964, and Hatakeyama,¹¹ in 1970, experimentally induced micro retention cysts of the parathyroid by stimulation with exogenous high doses of DHT(calci-

feral) and calcium. San Miguel, at the Ninth Meeting of the Columbian Society of Pathology, in

1966, reported a case of iatrogenic cystic parathyroid glands in a 17-year-old girl who was treated with large doses of calciferol and calcium following subtotal thyroidectomy. The finding that fluid from clinically apparent cysts is hormonally active (Wang)¹² would support the retention theory. One could postulate from the experimental findings of Selye and Hatakeyama that a functional parathyroid adenoma might induce cyst formation in the other parathyroids. Several cases of adenoma in one gland with cyst formation in another gland indeed have been reported.^{6,13}

Cystic Degeneration of Adenomas

Rodgers *et al.*,¹³ in reviewing parathyroid adenomas, found cystic degeneration in 9% of the cases studied. Norris¹⁴ review of parathyroid adenomas recorded that 89% were found in the inferior pole position, which corresponds

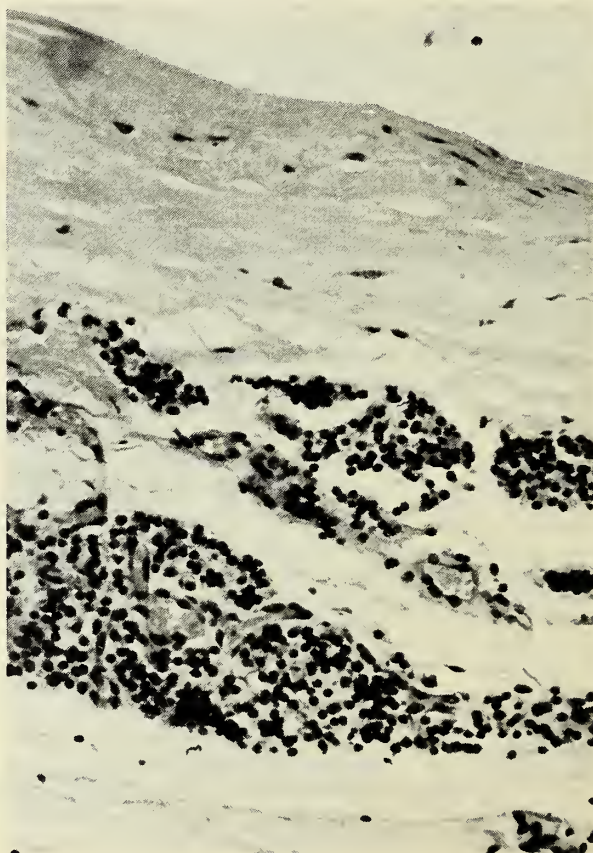


Figure 2

Numerous areas of parathyroid tissue could be seen outside the cyst wall.

well with the location of most parathyroid cysts. If parathyroid cysts arise from adenomic degeneration, it is reasonable to assume that the internal surface of some cysts could still retain large amounts of parathyroid tissue not yet degenerated. Pertinent microscopic findings in parathyroid cysts have been documented frequently.^{12,15-17}

Embryonic Theory

Gilmour¹⁸ in his papers on the embryology and histology of parathyroid glands, described three types of rudimentary structures, collectively known as Kursteiners canals.

Type I — Small solid buds of cells from the ventral surface of parathyroid III separate and vacuolate. They are definitely parathyroid in origin.

Type II — Gland-like alveoli, lined by cuboidal cells, extending

from the ventral surface of parathyroid III. Origin of these structures could be parathyroid or thymic cord (a tubular structure connecting parathyroid III and thymus III).

Kursteiners canals are only described for parathyroid III which corresponds to the location of most parathyroid cysts. Welti¹⁹ described thymic tissue in the wall of a parathyroid cyst which could be easily explained by an embryonic origin (Type II).

Branchiogenic cysts, thyroglossal duct cysts and thymic cysts are all held to be embryonic in origin. It would be logical to assume that parathyroids developing from the same precursors could produce cystic structures as well.

The epithelial lining of parathyroid cysts and cervical thymus cyst are similar according to Furuya.⁴ He concludes that their origins are also similar.

Comment

In review of the literature, most authors try to explain the origin of all parathyroid cysts by one of the four previously mentioned theories. However, no one theory can completely account for the wide variety of gross and microscopic findings. The present authors would suggest, therefore, that there are two pathological conditions which present as macrocysts of the parathyroids: true cysts which completely fulfill the criteria of parathyroid cysts and pseudocysts of the parathyroid, which are secondary to cystic degeneration of an adenoma.

References

A complete list of references for "Macrocysts of the Parathyroids: Case Report," may be obtained by writing the *Illinois Medical Journal*, 55 East Monroe, Suite 3510, Chicago 60603.

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Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July, 1979.

Case Report

Carcinoma Arising In A Sebaceous Cyst

Dr. Bruce Bauer: A sixty-eight year old white man was admitted to the hospital with a diagnosis of infected epidermoid cyst of the right preauricular area. The lesion had appeared 12-16 weeks prior to his first visit. Initially small and cystic, it became inflamed but resolved without drainage. The inflammation recurred 10 days before our examination and the mass became larger, measuring 3x2.5cm. Incision and drainage was performed and the patient placed on oral oxacillin. The lesion failed to resolve over the following three weeks. Granular tissue grew from the site of incision, with a spreading zone of inflammation around the lesion.

An excisional biopsy was attempted but it was found that the tumor was adherent to the parotid gland. The sections of the specimen showed a well differentiated squamous cell carcinoma with heavily keratinizing capillary fronds (Figure 1).

The overlying skin showed evidence of ulceration, but no evidence of atypical pre-malignant change. In one fragment, a portion of squamous epithelium with minimal atypia was seen under the skin. This appeared to be continuous with the normal epithelium, and suggested that it represented a remnant of cyst wall. Elsewhere, invasion of the stroma by small nests of tumor cells marked by fibroproliferative and lymphoplasmatic inflammation were present.

The wound was closed, but the skin immediately along the suture line broke down. We did not want to do further undermining pending final analysis for fear of spreading tumor.

In June of 1978, in the *Journal of Plastic and Reconstructive Surgery*, Becker described the cervicopectoral flap. This flap met a number of our essential requirements. It was well suited for wide excision of tumor. If we had planned a neck dissection (which did not seem required in

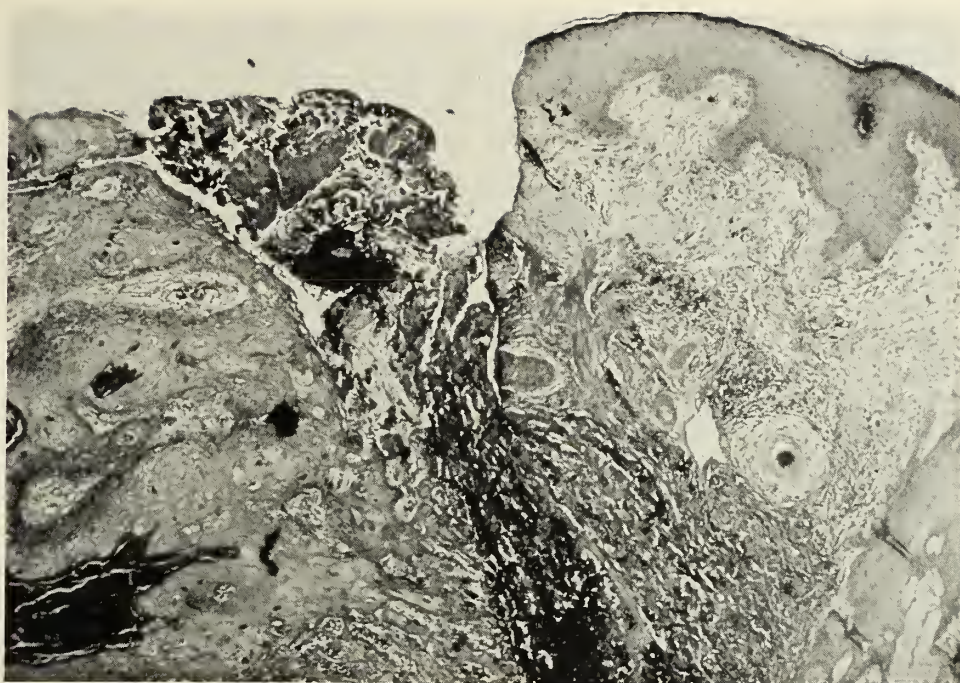


Figure 1

Section through wall of the cyst demonstrated well differentiated squamous cell carcinoma.

this case) it would give wide exposure to the neck area. It provided an excellent skin color match. It is a reliable flap based on the blood supply of the deltopectoral flap. The last requirement that it met was allowance for primary closure of the donor defect.

The wound was well healed one month post-operatively, with an excellent skin color match and minimal scar defect.

Reports from the Literature

Although little attention has been given to malignant degeneration of epidermoid and sebaceous cysts, 132 cases have been reported in the literature. Half of these have appeared in seven large series and the remainder in sporadic case reports. Given the number of cysts that are encountered, true incidence is impossible or extremely difficult to determine. The incidence has been estimated in the literature to vary from 1.1% to 9.2%. The compilation of 7 major series showed 65 carcinomas among 2697 cysts examined, an incidence of 2.4%.

A clinical study of the 132 cases of malignant sebaceous and other epidermoid cysts revealed that men and women are equally affected. The

majority of the patients were in the fifth decade or older, with an age group of 16 to 82 years. The tendency for the lesion to become malignant may increase as the patient grows older. Only a single black patient was reported.

Squamous cell carcinoma is noted in over 90% of these cases. Most were well differentiated. Surprisingly, most of these were found above the shoulder level. Several series reported a long duration and a high incidence of cyst recurrence. However, Peden, in the largest series of 832 cysts examined, did not find these significant. In a few patients, ulceration preceeded diagnosis of carcinoma. Metastasis has been reported in only five of these cases, two of those five in poorly differentiated lesions. The tumor appears to be slow-growing within the cyst wall, and invasion of the surrounding structures occurs late. Treatment is wide incision, as carried out in this case, with particular attention to those cases in which the cysts have been shelled out previously, and the diagnosis made incidentally. Simple enucleation of recurrent cysts should not be done. The decision about further excision of the contiguous structures should be dependent on the histological grade, and on whether the tumor extends beyond

the cyst wall. Recurrence is unlikely when wide local excision is done.

Summary

Malignant degeneration of sebaceous and other epidermoid cysts is uncommon but may occur in approximately 2.4% of cysts examined. It should be suspected in cases with atypical appearance, or a history of recurrence. All cysts must be examined histologically, and histological grade carefully noted when tumor is present. In the case reported of a well differentiated squamous cell carcinoma arising in an epidermal cyst, a wide excision was performed, including parotidectomy because of the histologic evidence of extension beyond the cyst. Based on literature review, recurrence or metastasis of the lesion in our patient is considered unlikely.

The occurrence of carcinoma in a sebaceous cyst is surely uncommon. Most surgeons have removed many sebaceous cysts and never seen a malignant lesion. In the reported series, surely the incidence of malignancy is overstated, either because the series is from an institution where unusual and difficult problems are treated, or be-

cause many routine appearing cysts were discarded without pathologic examination. McDowell, writing in 1979, continues to dispute with great cogency the occurrence of carcinoma in sebaceous cysts.

It is difficult to prove conclusively that a cancer arose in a cyst wall even though it clinically appears to have done so. As in this case, the cyst wall is so replaced by tumor and inflammatory tissue that little is left for diagnosis. The question of the tumor's origin within a cyst or in juxtaposition to it, remains.

Ultimately, it is apparent that when a cancer occurs in or with a sebaceous cyst, its appearance and course are much different from that usual for sebaceous cysts. Enlarging, recurrent, friable or bleeding lesions originally thought to be sebaceous cysts should be excised and studied with a much higher index of suspicion than the usual small rubbery lesions with malodorous contents. ◀

References

1. Becker, D.W.: "A Cervicopectoral Rotation Flap for Check Coverage," *Plast. Reconstr. Surg.* 61:868, 1978.
2. McDowell, F.: "When Is a Wen? Do We Need a Microscope to Diagnose One?" *Plast. Reconstr. Surg.* 63:555, 1979.

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Student Business Session in Action

AMA/SBS Annual Business Meeting Report

The Annual Business Meeting of the American Medical Association Student Business Section took place on July 21, 1979, at Chicago's Downtown Marriott Hotel. For ISMS/SBS the meeting was marked by the election of Chairperson David Aizuss to the Governing Council of AMA/SBS, the national student group within the AMA. It was also a time for the AMA/SBS to consider resolutions from its members for recommendation to the AMA House of Delegates and specific reference committees.

Some of the most important work at the AMA/SBS business meeting took place during the consideration of resolutions submitted to the SBS. These dealt with organization of representation within SBS, issues of concern to the medical student body as a whole and presentation of viewpoints from organized medicine regarding public health matters.

Representation within SBS remains a troubled issue, as the method of determining representation varies with regional organizational structures. The assembly recommended that the state medical societies be the first source of active student groups contacted by the AMA Department of Medical Student Affairs. Other school, regional or national organizations could be contacted where an active student group within the state medical society did not exist. It was recognized that, in some cases, delegates to SBS meetings would not be AMA members under this philosophy. Regional autonomy was also recognized, as the assembly provided for election of AMA/SBS Governing Council members through a regional

caucus structure. Finally, the group approved recommendation of voting privileges for medical students on AMA councils and committees.

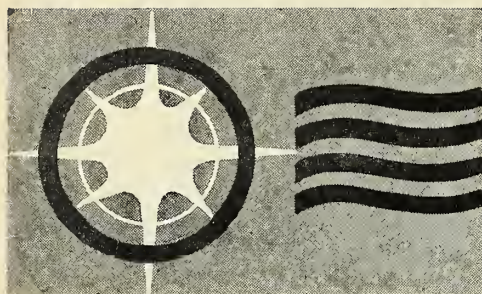
In matters of interest to the medical student body: consideration of a resolution on the National Health Service Corps; use of National Boards beyond their role in licensure and a resolution encouraging state medical societies to seek student input when asked to endorse state legislation affecting medical students. An increase in the counseling support systems available to medical students met with a positive response from the assembly.

Response of AMA House to AMA/SBS Proposals

Response to SBS proposals by the AMA House of Delegates was in general favorable. An SBS proposal noting the superiority of breast feeding in infant nutrition and condemning the inappropriate sale of formula was referred to the AMA Board of Trustees for further study, and report back to the 1979 Interim Meeting. SBS concern regarding the consistent quality of nursing home care was supported by the house.

For SBS members, the 1979 annual AMA meetings in Chicago can be summarized as a time when the conscience of AMA members found voices in the organization. It is also clear that both social issues and many questions of medical student interest were clarified in a beneficial way. We look to such discussions as a source of future consideration pertinent to solution of problems raised.

David J. Dries
Secretary/Editor



membership forum

Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

Medical Clerks To The Legal Establishment

Perhaps we were unfair to our lawyer friends in the emotional aftermath of the malpractice crisis. We accused them of greed, abuse of constitutional guarantee of equal protection, legal harassment, milking insurance money out of the medical profession. Perhaps we overreacted? They are nice guys, even our allies. Times have changed, or have they?

My practice has certainly changed. I used to deal with one or two legal matters a year. Now, there is a constant stack of correspondence to attorneys on my desk. They represent my patients in various litigations following back injury related to a five inch scratch on the fender or slipping on a banana peel in front of the supermarket. The medical charges for such accidents were negligible. But now in an "heroic struggle for justice," I write reports, give depositions and travel to the county seat

for court testimony. I feel like a medical clerk to the legal establishment. Some patients saw the attorney first and came to me after assured that the case could be a profitable legal process. The legal costs of such trivial accidents must be in the thousands of dollars. Perhaps we should charge our lawyer friends 33% of their take?

The truth is that this development is alarming and irritating. I do not serve my patient in the spirit of my profession. I do not think that I serve justice or the nation. I feel that I am part of a dark conspiracy and a voice inside me tells that something is wrong with the judicial system. Litigation has become a social disease of national proportion. Somebody should tell somebody that we are healers, not medical sidekicks to a legal gimmick.

James Scott, M.D.
Streator

Influence of Colonoscopy on Colon Surgery

The introduction of fiber fascicles into the gastrointestinal tract for the transmission of light images has changed our diagnostic techniques in colon disease from two-dimensional shadows to almost lifelike color pictures and has profoundly altered our therapeutic approaches to diseases of the colon. Fiberoptics have not replaced X-ray studies; they frequently are supplementary diagnostic aids and by their simplicity and effectiveness promise to change indications for certain open surgical procedures in the future.

The initial skepticism toward colonoscopy was justified in the past. Fiberoptic gastroscopy was plagued by trial and error periods, beginning from the original side-vision Hirschowitz scope to the ultimate forward-vision controllable tip instrument as used today. In between came the era of gastrocameras. No doubt, it was an ex-

pensive road to travel for those who became interested in this new and fascinating field in medicine. Surprisingly, colonoscopes have more or less remained unchanged in structure and mechanism. This is probably based on experience gained with gastroscopy. Efforts to add more operating channels to single channel scopes, for example, have been less successful than expected and appear now almost unnecessary. Thereby, instruments became heavier, thicker and more difficult to pass into the colon. There are still problems remaining, for example, a built in, selective stiffening mechanism would be helpful and would prevent repetitious coiling of the instrument.

Nevertheless, direct visualization of almost the entire length of the colon and the introduction of snares and operating biopsy forceps, have altered diagnostic approaches and have changed directions for colon surgery of polyps and carcinoma. There may be some doubt as to whether colon cancer is directly related to polyp formation; the large number of colonic polyps removed by this method and the occurrence of all stages of neoplasia therein from cell atypia to carcinoma *in situ* to infiltrating adenocarcinoma speaks for itself. Frequency of neoplastic involvement is directly related to polyp size. Combined occurrence of polyps and frank carcinoma is not uncommon. To the contrary, primary sessile carcinoma in its early stages is relatively rare, except for villous adenoma. These conclusions lead one to believe that if, technically feasible, all polyps should be removed. Polyp size is an important parameter for removal since larger polyps over 1.5cm statistically are more cancerous. Optimal efforts by surgeons to remove all accessible polyps cannot always be achieved. Colonoscopy has its limitations, "dead" angles exist around the natural flexures of the colon, at the hepatic and the splenic flex-

ure as well as in the upper sigmoid. Chronic constrictive changes in the sigmoid colon can present real obstacles. It is here that most perforations occur. Many technical "tricks" are often necessary to place a polyp so that the wire snare slips over its adenomatous part and that the stalk can be placed at a safe angle and distance from the bowel wall before cautery current is applied. Evacuation of multiple polyps presents problems after snaring because practically each of them requires removal of the entire length of the scope. The use of later cleaning enemas for polyp removal is unsatisfactory. A cleaning enema after polyp removal could cause perforation of the bowel at cautery sites. Pathological examination of all polyps is still considered most important. More experience with colonoscopic polypectomy might verify that small polyps usually are not cancerous. Stalk invasion however, remains a serious diagnostic problem since cautery destroys the critical area for microscopic examination. Later re-biopsy of the stalk area is helpful as long as the area can be clearly marked for future identification. If stalk invasion is diagnosed, local surgical excision of this area is indicated as the minimal procedure.

While multiple polyps can be removed by colonoscopy, in colon polyposis and in the presence of a large number, perhaps 50 to 60 polyps, surgical resection still appears the treatment of choice, particularly since such a patient would have a potentially abnormal colon mucosa anyhow with the propensity to develop more polyps in the future. Partial colon resections alone with repeated colonoscopy have avoided total colectomy in a number of patients who, over several years of observation, have shown occasional polyps but otherwise remained symptom free. The utilization of pulsating laser light is promising and appears almost certain in the near future.

If removal of all polypoid struc-

tures is important, more aggressive utilization of colon endoscopy should be expected from all surgeons. Dr. Gilbertson and his group have shown that the incidence of colon cancer can be reduced by the judicious use of procto-sigmoidoscopy over a given period of time. Using the same parameters, one should expect further improvements in cancer detection and earlier treatment with the aid of the new flexible short colonoscope for the left-sided colon examination. One would be surprised to find how long the sigmoid colon really is and how little of it had been examined previously with the rigid scope. Technically speaking, the rigid scope is about as outmoded as the wooden stethoscope.

If continuous medical education in surgery remains meaningful, it should include the possibility for the surgeon to master new techniques. Likewise, responsible surgical committees must provide the necessary guidelines for a safe transition to the routine use of the flexible scope instead of the rigid proctoscope. It is recognized that 75% of all perforations occur in the sigmoid. So, special caution must be taken to avoid dangerous situations particularly in diverticulitis or other inflammatory conditions of the bowel. Some perforations will be unavoidable. Proper training and adequate experience with older instruments are necessary and essential for a surgeon to make this transition. Yet, someone who endured five years of rigid surgical training and mastered sophisticated procedures such as vagotomy, bile duct operations, etc., should be sufficiently adept to start thinking "flexible" instead of "rigid" sigmoidoscopy.

In my opinion, this transition has very broad implications and most certainly would lead to a significant decrease in left-side colon cancer by the logical application of available technical means. ◀

—Rudolph W. Roesel, M.D.
Chicago

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Internist with special interest in Cardiology. Good EKG volume, exclusive interpretation privilege. New 4 bed Special Care Unit. Some general practice required. Guaranteed Salary. Located within 35 minutes of Southern Illinois University Medical School Carbondale, Cape Girardeau, Mo. and Paducah, Ky. Contact: E. A. Helfrich, Adm. or Ken Simpson, Asst. Adm. Union County Hospital, 517 N. Main St., Anna, 62906. Telephone Collect: 618-833-5155 (12)

DANVILLE: More than would be expected in a city of 43,000. Area population of 190,000 served by two medium sized community hospitals. An industrial medicine specialist or a neurosurgeon would find above average opportunities for professional growth. Area offers all the advantages of a smaller city life plus easy access to major urban areas. CONTACT: Richard V. Liven-good, President, Lakeview Medical Center, 812 North Logan Avenue, Danville, 61832. (9)

FAIRBURY: Primary Care Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (12)

FAIRBURY: Family Practice Physicians—excellent practice opportunities in a thriving rural community; enjoy life and practice, we offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultural activities; join the active medical staff of a growing 112-bed JCAH accredited community hospital. Send curriculum vitae in confidence to Frank Brady, Administrator, Fairbury Hospital, 519 South 5th St., Fairbury, 61739 (1)

FLORA: Family Practice Physician is needed in Flora, Ill., a stable community in Clay County in south central Illinois. Financing available with a guaranteed income. We have good schools, roads, hospital and neighbors. Contact J. Luff, Administrator, Clay County Hospital Flora, Ill. 62839 (618-662-2131). (1)

FREEPORT: Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

GALESBURG: Population 38,000. Western Illinois, diversified manufacturing and agri-business—stable employment. Excellent cultural, recreational opportunities, home of Knox and Carl Sandburg Colleges. Practice opportunities in various specialties. Financial assistance available. CONTACT: David D. Fleming, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401, 309/343-8131. (1)

GARDNER: Population 2500 (surrounding area 20,000). Opportunity for physician seeking family practice. Very modern medical building available, only one dentist in building (previous physician deceased in May, 79). Very pleasant rural/industrial community only 30 miles from Joliet. Will assist with financing. CONTACT: Chuck Chladek, Depot St., Gardner 60424. Phone (815) 237-2366 or (815) 584-1152. (1)

GREENUP: Family Practitioner, present physician retiring. Office building, complete with pharmacy and X-ray unit for sale. Factories close, financial assistance available. Good community and practice. Located 190 miles south of Chicago, 20 to 25 miles from Eastern Illinois University and Lakeland Jr. College. Contact: Nicholas J. Beck, M.D., 300 N. Mill St., Greenup, 62428. Phone: 217-923-3311 or 217-923-5134. (1)

KEOKUK, IA: Population 15,000. Opening for family and speciality physicians. Hospital currently undergoing 9.5 million dollar expansion project. Twenty-two physicians at present. Sixty miles from Burlington, IA. Complete office facilities. Financial assistance available. Join our progressive community situated on the banks of the beautiful Mississippi. Contact: Dr. Lynn Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, IA 52632, AC 319-524-7150. (1)

MATTOON: Family practitioner or internist for rewarding primary care practice. Fully equipped office available—New 210-bed hospital (open staff)—Financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient draw of 75,000. Contact: A. P. Rauwolf, M.D., 1120 Wabash, Mattoon, 61938. (217) 234-6253. (10)

MOUNT CARMEL: Growing southern Illinois community of 10,000 located 40 miles north of Evansville, Indiana on the Wabash River. Acute care hospital offering a wide range of services located in the community. Near universities and colleges. Guaranteed income and other financial assistance offered. Contact: William E. Lee, 1418 College Drive, Mount Carmel 62863 (618-262-4121). (1)

OBLONG: Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

OLNEY: Southeastern community, population 10,000. Anesthesiologist desired to head department. Thirty-two physicians on staff. Recently completed hospital construction, five new operating rooms. Type of compensation negotiable. Junior College and all recreational facilities nearby. Contact: Harold Kaseff, Administrator, 800 East Locust Street, Olney, 62450. AC 618/395-2131. (8)

OQUAWKA: Population of County—8,000. Opening in new medical clinic. Ninety-five miles from Peoria. Complete office facilities. Near colleges. All recreational facilities nearby. CONTACT: HENDERSON COUNTY HEALTH DEPARTMENT, P.O. Box 186, Oquawka, 61469, (309) 867-2202. (10)

SOUTHERN ILLINOIS: Opening in newly remodeled community Health Services Center located in Cairo adjacent to hospital. Target population 20,000. Six physicians, two dentists, counseling services, and outpatient lab at present. Financial assistance available. Near university and colleges. Wide range of recreational facilities. CONTACT: Steve Miller, 529 Cross St., Cairo 62914 (618) 734-4200 (8)

STERLING/ROCK FALLS: Primary Care physicians

needed to join our expanding and progressive medical community. Progressive 167 bed JCAH hospital serving 60,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact Edward A. Andersen, Community General Hospital, Sterling, 61081 (815) 625-0400. (8)

SYCAMORE: Associate Desired—for July, 1980. Family practitioner to join two family physicians and internist in a newly formed group. Situated 112 kms west of Chicago in a semi-rural area. Family practice oriented hospital, with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D. (Director), 954 West State Street, Sycamore, 60178, (815) 895-9144. (9)

VANDALIA: Population 5,500. Progressive town in rural Fayette County urgently needs family practice physicians, also internist and pediatrician. Hospital serves county population of 25,000. Seven physicians at present. Sixty miles from St. Louis on I-70. Office facilities available, also financial assistance. CONTACT: John Leckrone, Administrator, Fayette County Hospital, Vandalia. Phone collect 618/283-1231. (1)

WHITE HALL & ROODHOUSE: Combined population of 6000 (2 miles apart), 3 physicians. 16,000 persons. 30 bed hospital, built 1978. Complete primary care diagnostic support. Group or solo. Hospital assistance. One hour from major medical complexes and medical schools. Family communities w/sound education and abundant recreation. Contact Larry Bear, White Hall Hospital, 407 N. Main, White Hall 62092. (217-374-2121). (1)

CHAIRPERSON, DEPARTMENT OF SURGERY

Grant Hospital of Chicago, a 508 bed general hospital, recently affiliated with Rush-Presbyterian-St. Luke's Medical Center, is seeking an experienced Surgeon with Board Certification to lead its growing Department of Surgery. The position requires a full-time, geographic commitment and offers an attractive financial package. Applicant must qualify for University appointment at Rush Medical College and be interested in developing teaching programs.

Respond to: Louis C. Johnston, M.D., Medical Director, Grant Hospital of Chicago, 550 West Webster Avenue, Chicago, Illinois, 60614. (312) 883-2000.

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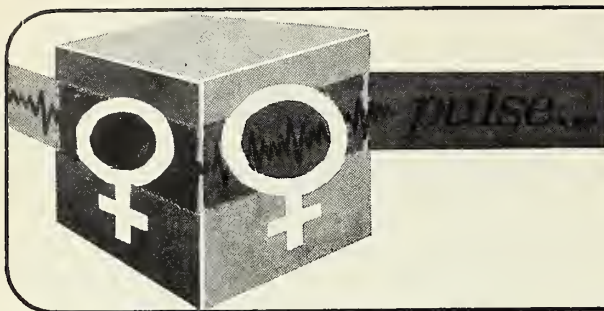
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BY MRS. R. S. HOOVER, ISMSA
PRESIDENT

Shape Up For Life

The Shape Up for Life campaign is the AMA Auxiliary's new nationwide health project. Fueled by such slogans as "Don't just sit there, shape up!" and "Eating right is never having to say you're on a diet," the Shape Up for Life campaign is aimed at keeping Americans healthy. The AMAA Health Projects Committee feels that it is never too soon or too late to begin eating properly or exercising regularly. Good nutritional habits and proper diet, as well as regular exercise for physical fitness, are the goals of the campaign. The Auxiliary has had a long-time interest in making people aware of what they can do to keep themselves healthy. The Shape Up campaign is to focus on the goal of improving the lifestyle of Americans, while contributing to the health care industry's Voluntary Effort for cost containment.

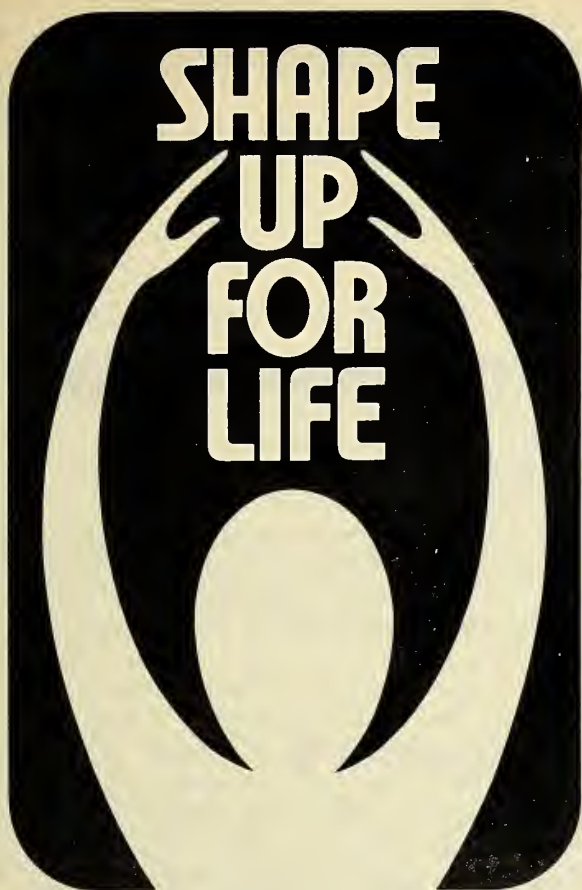
At the special Health Projects seminar prior to the AMAA convention, the introduction of the Shape Up campaign took star billing. To get the campaign off to a good start, Health Projects Committee members, including Illinois' Mrs. Edward Szewczyk, North Central Regional Health Projects Chairman, presented the striking blue

and white posters and pamphlets which will soon be distributed nationally. The special campaign logo was designed for AMAA by Draper Daniels, Inc., Advertising, and will appear on all campaign materials. The project is a two year effort. The focus for 1979-1980 is food for fitness; and for 1980-1981, a second phase will focus on physical fitness.

Dr. Philip L. White, Director of the AMA Department of Foods and Nutrition, was featured speaker at the seminar. He stressed the importance of nutrition education for the public as a preventive measure; one which would help insure health and vitality (and therefore productivity) for Americans.

Three major nutritional problems facing our population were discussed. First, a limited variety of foods in the diet is a common problem which can mean nutrient deficiencies—particularly in the elderly and teenage females. Secondly, too much food combined with too little exercise equals an overweight problem. Thirdly, he cited malnutrition, deficiencies in vitamins, minerals, proteins, etc. "America's number one nutritional problem," said Dr. White, "is that of overweight, brought on by overindulgence and underactivity." Dr. White recommended this concept of good nutrition—following the recommended dietary allowances (USRDA), with a wide variety of foods, and the size and number of portions in moderation. Good eating habits, he said, "Can promote a positive personal, family and community image."

The Shape Up for Life pamphlet contains basic information on nutrition and health, written in an interesting and easily followed style. A daily food guide is included showing servings recommended for children, preteens, teens and adults, of the four basic food groups, milk, meat, fruits/vegetables, and breads/cereals. A "magic formula" for weight loss—eat less and exercise more—is stressed. Tips for successful dieting based on moderation and common sense are included. Regular exercise is emphasized as an essential part of a reducing plan.



Materials available include the poster and pamphlets suitable for placing in doctor's offices, schools, businesses, industries, civic centers, clinics and other public buildings. Ideas for community projects and resources for materials are included in the newly revised Food for Fitness Package Program. In addition, watch your TV and listen to your radio for public service announcements which will carry the "Shape Up for Life" message to millions of homes this fall. Materials for the campaign can be ordered from the AMA Auxiliary, 535 N. Dearborn Street, Chicago, Illinois 60610. The Shape Up posters and pamphlets are free of charge, and the Food for Fitness Package Program, \$1.00 each.

Our ISMS Auxiliary Nutrition Chairman is Mrs. Wayne Kassel. Further information on the Shape Up for Life Program may be obtained from her. We will also feature the materials at our Fall Conference in Bloomington on October 17. Let's all focus in on the AMA Auxiliary's new nationwide campaign and "Shape Up for Life." ◀

Clinics for Crippled Children Listed for October

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 25 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Oct. 2 Quincy—Blessing Hospital
- Oct. 2 Park Ridge Cardiac—Lutheran Gen. Hosp.
- Oct. 3 Hinsdale—Hinsdale Sanitarium
- Oct. 3 Cairo—Public Health Department
- Oct. 4 Sterling—Community General Hospital
- Oct. 4 Effingham—St. Anthony Memorial Hosp.
- Oct. 4 Lake County Cardiac—Victory Mem. Hosp.
- Oct. 5 Division Cardiac—U. of I. at the Medical Center
- Oct. 9 East St. Louis—Christian Welfare Hosp.
- Oct. 9 Peoria General—St. Francis Hospital
- Oct. 10 Elgin (MM)—Sherman Hospital
- Oct. 10 Champaign-Urbana—McKinley Hospital
- Oct. 10 Joliet—St. Joseph's Hospital
- Oct. 11 Springfield General—St. John's Hospital
- Oct. 11 Kankakee General—St. Mary's Hospital
- Oct. 12 Chicago Heights Cardiac—St. James Hosp.
- Oct. 15 Maywood—Loyola Medical Center
- Oct. 15 Peoria Cardiac—St. Francis Hospital
- Oct. 16 Decatur—Decatur Memorial Hospital
- Oct. 17 Chicago Heights General—St. James Hosp.
- Oct. 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Oct. 18 Bloomington—Mennonite Hospital
- Oct. 18 Rockford—St. Anthony's Hospital
- Oct. 19 Kankakee Cardiac—St. Mary's Hospital
- Oct. 23 Belleville—St. Elizabeth's Hospital
- Oct. 23 Rock Island General—Moline Public Hosp.
- Oct. 23 Peoria General—St. Francis Hospital
- Oct. 24 Aurora—Mercy Center for Health Care Services
- Oct. 24 Springfield Ped-Neuro—St. John's Hosp.
- Oct. 24 Centralia—St. Mary's Hospital
- Oct. 24 Metropolis—Massac Memorial Hospital
- Oct. 26 Chicago Heights Cardiac—St. James Hosp.
- Oct. 26 Evanston—St. Francis Hospital
- Oct. 29 Peoria Cardiac—St. Francis Hospital
- Oct. 31 Mt. Vernon—Good Samaritan Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



News Update

AAMA, Illinois Society, has chapters in 24 counties. Counties with chapters include:

1. Cook (7 chapters)
2. Coles/Cumberland
3. DeKalb
4. DuPage
5. Jefferson/Hamilton
6. Kane
7. Macon
8. McHenry
9. McLean
10. Morgan/Scott
11. Peoria
12. Randolph
13. Sangamon
14. Shawnee (Harrisburg)
15. Spoon River (Cuba)
16. St. Clair
17. Vermilion
18. Will/Grundy
19. Rock Island
20. Winnebago

Medical Assistants in counties where there are no chapters are encouraged to become **MEMBERS AT LARGE**.

It is the goal of the Illinois Society to have a local chapter in every county. This is **NOT IMPOSSIBLE**. With Illinois Physicians' encouragement of membership in this tri-level professional organization, it **CAN** be accomplished.

Coming Events

9/16/79—Annual Educational Symposium
Ramada Inn—Bloomington, IL

11/11/79—Annual Personal Development Seminar, Flossmoor Country Club—Flossmoor, IL (additional information will appear in a future IMJ).

9/28/79—10/6/79—AAMA National Convention—New Orleans, LA.

During the Educational Symposium on September 16, 1979, the following subjects will be covered: "Current Trends in Mental Health Care," "Patient and Problem Oriented Medical Records," "Deadlock: Health Documentation after a Riot," "Best of Care to Come" (Plastic Surgery), and "Dying a Good Death: The Hospice Alternative."

Members, non-members, physicians, and auxiliary members are invited to attend any or all of the upcoming educational workshop.

Cissy Egly, CMA, president, Illinois Society and Luella V. Mitchell, chairman, Illinois Society Public Relations Committee, were honored in being a part of the AMA meeting recently at the Chicago Marriott Hotel. The Illinois Society President was one of the hostesses during the AAMA "coffee and conversation" reception. The Illinois Society Public Relations Chairman was invited by the AAMA Kentucky Society to attend a brunch for Hoyt D. Gardner, M.D. (Kentucky) and the Presidential Inauguration, when Dr. Gardner was installed as the 134th president of AMA.

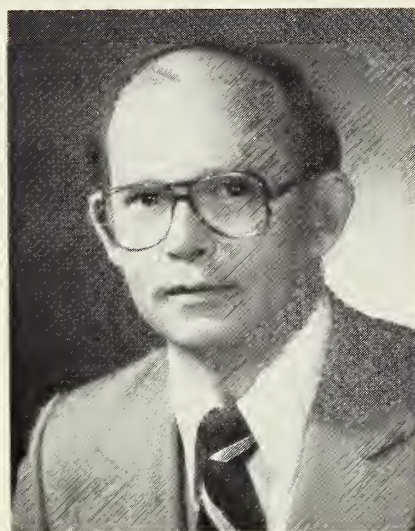
COMMUNICATION is a priority of the AAMA Illinois Society this year. We are **COMMUNICATING** thru our monthly page in the *IMJ* to you and would like you to **COMMUNICATE** with us. Let us know what you think of our articles; what additional information you would like about AAMA Illinois Society; what educational programs you would like the AAMA Illinois Society to plan; or any suggestions or comments.

If you would like to **COMMUNICATE** with us, contact: Cissy A. Egly, CMA., president, 1413 Midland Court, Joliet, IL 60436 or Luella V. Mitchell, chairman, Public Relations Committee, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

President's Page

Nearly all of our political comment originates in Washington. Washington politicians, after talking things over with each other, relay misinformation to Washington journalists who, after further intramural discussion, print it where it is thoughtfully read by the same politicians. It is the only completely successful closed system for recycling of garbage that has even been devised.

Economist John Kenneth Galbraith



Washington's Recycling System

Mr. Galbraith's words have startling applicability to health planning.

Federal planners have a unique, inbred ability to communicate only with those who embrace the bureaucratic philosophy. Based on these contacts, they prepare reports which are released to the media . . . and the media relays the distorted perspective to the public, politicians and the very planners who initiated the discussion. After reading the media account, planners become convinced they have developed an ideal program. Simply stated, the cycle begins and ends with those who initiated it. What escapes detection are the iron-fisted demands that intimidate local planning agencies into accepting the terms "compliance" and "success" as synonymous.

The federal government is increasingly prone to view itself as the ultimate solution to all problems. The harvest of this concept is a further reliance on government, despite the monumental liabilities. Most damning is that this misconception allows the bureaucracy to activate the system for recycling ill-conceived ideas. Health planning is a classic example.

The federal health planning law states that the process should flow from the bottom up. In reality, the guidelines have been formulated, circulated and recycled in Washington, then forced upon local planning bodies. Timid local agencies have promoted the recycling system by bowing to federal dictates.

One thing is certain: Government's garbage recycling system will continue its efficient "pickups" and "deliveries". It is only through physicians' involvement that creative ideas can be separated from the recycled "regulatory garbage" that has characterized federal health planning. We must not allow the garbage to become more fetid. ◀

A handwritten signature in dark ink, reading "P. John Seward, M.D.". The signature is fluid and cursive, with a large, stylized "P" and "S".

P. John Seward, M.D., President

COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to or use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reaction with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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Doctor's News

INTEGRATED QUALITY ASSURANCE—is the subject of several one-day programs co-sponsored by ISMS and the American Hospital Association later this year. The programs are designed for physicians and hospital administrators responsible for quality assurance activities. New JCAH standards allowing individual hospital discretion in determining means to meet quality care reviews have prompted the seminars, which will focus jointly on the JCAH expectations and PSRO requirements. The programs have been accredited for six hours of Category 1 CME credit, and require a \$75 registration fee. The first is scheduled for September 21, at the Oak Brook Hyatt House. The locations of repeat programs on September 27, October 4 and October 11 will be announced at a later date. For further information and registration, please contact Mr. Larry Borress at the ISMS offices.

CONFERENCE ANNOUNCED—The National Institutes of Health will sponsor a consensus development conference entitled "The Use of Microprocessor-Based 'Intelligent' Machines in Patient Care," in Silver Spring, Maryland, October 17-19. The conference, which immediately follows the third annual Symposium on Computer Applications in Patient Care, has tentatively been approved for five hours of Category 1 CME credit. Topics will focus on recent advances and future developments, in conjunction with social, legal and ethical issues. For further information, contact Henry S. Eden, M.D., Assistant to the Chief, Biomedical Engineering and Instrumentation Branch, DRS, Building 13, Room 3W13, National Institutes of Health, Bethesda, Maryland 20205; or call (301) 496-5771.

PHYSICIAN'S PRACTICE OPPORTUNITY FAIR—The SIU School of Medicine, in cooperation with the Sangamon County Medical Society and ISMS, has announced that a day-long meeting will be held September 26, at St. John's Hospital in Springfield, to encourage physician recruitment. The goal of the fair is to allow representatives from those Illinois communities seeking a physician an opportunity to meet resident physicians and students. Medical students and residents from Illinois, Indiana and Missouri training programs have been invited to attend. Interested persons may contact John F. Record, Office of Health Systems Research, at 217-782-5772.

OPINION POLL ANNOUNCED—The National Opinion Research Center is conducting an opinion poll of physicians and regarding medical practice expenditures. A random sample of 12,000 physicians in 18 specialties will be contacted for a brief telephone interview. The study has been endorsed by the American Academy of Pediatrics.

NORC has asked that the ISMS members be aware of the study, which was first announced by a direct mailing describing details. Data collected will be analyzed, their report states, with the aim of influencing better health insurance reimbursements in the face of inflationary practice costs. All reports will be in statistical summary form only, with no possible individual identification.

ELVEN J. BERKHEISER PRIZE ANNOUNCED—The Institute of Medicine of Chicago has announced that competition is open for their annual \$750 prize for best thesis for original research work in the field of orthopaedic surgery. Requirements for the competition are that most of the work must have been completed in a metropolitan Chicago institution, and may not have been published prior to submission. Competition is open to physicians who received their M.D. degree six years or less prior to July 1, 1979, excluding active duty in the armed forces.

Manuscripts and resumes must be received by the Secretary of the Institute of Medicine of Chicago no later than November 15, 1979. Applicants may address questions or submissions to: The Institute of Medicine of Chicago, 332 S. Michigan, Chicago 60604.

PHYSICIANS IN THE NEWS—**Henry P. Russe, M.D.**, Chicago, has been appointed associate dean, medical sciences and services, Rush Medical College, and assistant vice president for medical affairs, Rush-Presbyterian-St. Luke's Medical Center. Dr. Russe is president of the Institute of Medicine of Chicago and past president of the Chicago Society of Internal Medicine . . . **Mark H. Lepper, M.D.**, Hinsdale, has been named vice president, inter-institutional affairs at Rush-Presbyterian-St. Luke's Medical Center. Dr. Lepper succeeds Leo M. Henikoff, M.D., who is leaving to become dean of Temple University School of Medicine . . . **Harold A. Paul, M.D.**, LaGrange Park, has been named assistant vice president for inter-institutional affairs at Rush.

Illinois physicians recently awarded fellowships by the American College of Cardiology are: **Winston N. Block, Jr., M.D.**, Quincy, **Robert N. Gamble, M.D.**, Evanston, **William In Ki Kim, M.D.**, Elk Grove Village, **Rangson R. Ratan, M.D.**, Peoria, and Chicago physicians **Richard Davison, M.D.**, and **Tom R. McMeester, M.D.** . . . **E. Stephen Kurtides**, Evanston, associate professor of clinical medicine at Northwestern University Medical School, was recently named chairman of the department of medicine for the Evanston Hospital Corporation, which encompasses Evanston Hospital and Glenbrook Hospital in Glenview . . . **Richard C. Bubolz, M.D.**, Chicago, recently received the Golden Clock award from Abbott Laboratories, commemorating 50 years of service and dedication to medicine.

VALPO ALUMNI RECALLED—A group of physician alumni of Valparaiso University are attempting to identify and bring together those "Valpo" graduates who eventually joined the medical profession. A total of 189 persons (24 of whom are Illinois physicians) from the classes 1926 through 1979, residing in a matrix from Hawaii to Massachusetts and Oregon to Florida, have already been contacted. Any ISMS member who completed undergraduate training at Valparaiso and would like to assist in this effort, which is designed to bring about an MD-alum reunion during homecoming weekend, may contact John R. Poncher, M.D., 1101 E. Glendale Boulevard, Valparaiso, IND 46383.

NEWS FROM ASAE—The American Society of Association Executives (ASAE) has announced that Richard A. Ott, director of the ISMS Division of Publications, Medical-Legal and Mental Health, has earned the title of Certified Association Executive. Mr. Ott qualified for this certification by successfully passing intensive examinations and fulfilling prescribed standards of tenure, performance and conduct in over 12 years with ISMS as a staff executive.

ACCENT ON YOUTH—will provide the focus for a special program on the mornings of November 8 and 10, 1979, in Albuquerque, New Mexico, intended to familiarize the practicing physician with new frontiers of medicine in pediatrics. Topics will include problem pregnancy, high-risk infants, surgical emergencies in newborns, pediatric oncology and adolescent medicine. More information about the symposium, which is approved for 6 hours of Category 1 CME credit, may be obtained by writing the American Medical Women's Association, 1740 Broadway, New York, NY 10019.

RESOLUTION DEADLINE ANNOUNCED—The ISMS House of Delegates Interim Session will convene November 10-11, 1979, at the Holiday Inn in Decatur, Illinois. Resolutions proposed for consideration at the Interim Session must be received in the ISMS offices no later than October 13, 1979. Those received at a later date will be considered late resolutions and require special consideration for inclusion at the Interim Session.



California Seeks to Limit Residency Training

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey Holt, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

The California Office of Statewide Health Planning and Development has submitted a report which suggests radical changes in residency training within the state which also carries profound implications for the relationship between physician education and the state.

The California report reaches the following conclusions:

1. California has an oversupply of physicians—the Dr./pt. ratio is much higher than the national average.
2. Medical specialists in California are increasing at twice the rate of the population.
3. An excess supply of specialists adds to the cost of medical care and is not in the public interest.
4. California has a shortage of primary care physicians.

The California report calls for a reduction of medical specialty residency positions and an increase in Family Practice residency positions. The report calls for implementing these recommendations by empowering the Office of Statewide Health Planning and Development to certify medical residency programs only *as needed* to effect a more desirable balance of physicians in California.

As a final measure, the report suggests: "Additional separate and supplemental legislation could enable the Board of Medical Quality Assurance, Division of Licensing, to withhold initial California licensure from any physician who is enrolled in an uncertified residency program."

Proposed Limitations in Other States

New York—The statewide Health Coordinating Council has recommended that the distribution of residency programs be manipulated by changes in reimbursement policy for training programs and for medical care. Training programs in oversupplied areas might lose their state subsidies. Further reimbursement for medical services would be linked to manpower planning needs and Medicare/Medicaid reimbursement differentials between "primary care" and specialty services would be reduced.

Hawaii—House Bill 1518 in Hawaii would provide that the state planning agency determine the "need" for physicians in the state on a yearly basis, and the Board of Medical Examiners would issue licenses only when a need has been determined to exist.

Rhode Island—The Office of Health System Planning in Rhode Island is circulating a proposal to require a certificate-of-need as a prerequisite to the granting of a medical license.

Florida and Maine have for years had an informal system of refusing medical licenses to physicians of retirement age. Such restriction is aimed at reducing the number of retired, part-time physicians who would cut into the practice of younger, full-time physicians in the state. Neither state grants automatic reciprocity of medical licensure.

Implications of State Control of Physician Training and Licensure

The above proposals reflect a trend towards state control of medicine, treating medicine as a

national resource much like the electrical or telephone industry. A state may have some justification for allocating subsidies for training and physician reimbursement for services along its manpower needs (as in the New York proposal). But the limitations proposed on *licensure* based on manpower needs would limit physicians as individuals in a way no other professional group is limited. These proposals infringe on individual freedom and are of questionable constitutionality. The take-home lesson for the medical profession is that our failure as a group to voluntarily fill national health manpower needs is leading to

state attempts to regulate the medical profession to fulfill those needs. A head-in-the-sand, "no control whatever" attitude on the part of physicians towards *any* regulation will result in ever tightening control over individual freedom of career choice for physicians. We must develop and support legislation which addresses national manpower needs while maintaining individual freedom of choice for physicians; we must oppose legislation which attempts to manipulate physician distribution by infringing on the liberty of the individual. ◀

Viewbox

(Continued from page 157)

Answer: (A) Ectopic Kidney



Figure 3

DISCUSSION: The exam is not normal. There is supero-medial displacement of the sigmoid colon seen on the A-P film. The lateral film shows anterior displacement of the sigmoid away from the top of the sacrum.

The mucosa is normal (eliminating ulcerative colitis) suggesting that the colon is being merely displaced but not invaded. Absence of pelvic fracture or history of bleeding disorder should eliminate hematoma.

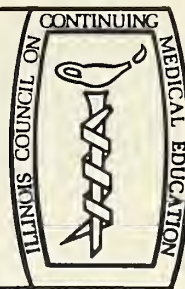
The key to the correct diagnosis of ectopic kidney is that the splenic flexure is too medial as it now occupies the area of the empty renal fossa.

An ectopic kidney situated this low is called a pelvic or sacral kidney. A pelvic kidney is often not merely misplaced but also malrotated as can be seen by the lateral orientation of the renal pelvis with the calyces pointing medially. The short ureter seen between the bottom of the iliac bone and the bladder is a testimony to the fact that this kidney never ascended any higher from its pelvic embryonic origin. Pelvic kidneys may be associated with a variety of anomalies such as agenesis of the other kidney, or hypoplastic or absent vagina.

The importance of confirming the diagnosis with IVP lies in avoiding biopsy or surgery of this mass which may displace the colon or be palpated on physical exam. ◀

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

October

Acute Care

Burns

For: MD's. Dinner/lecture, Oct. 23, Highland Park. Speaker: Charles Drueck, MD. Sponsor: Highland Park Hospital, 718 Glenview Ave., Highland Park 60035. Reg. deadline: 10/12. Fee: \$10. Reg. limit: 60. Credit: AMA Category 1, 1 hour. Contact: Arnold Goldstein, MD. Phone: 312/432-8000 x 4000.

Alcoholism

Seminar Series on Alcohol and Drug Abuse

For: GP's, Internists, Psychiatrists. Seminar, Oct. 12-13, Sheraton Plaza, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago, IL 60612. Reg. limit: 150. Fee: \$50. Credit: AMA Category 1, 12 hours. Contact: Sue Korienek. Phone: 312/996-8025.

Cardiac Rehabilitation

Total Cardiac Rehabilitation Process

For: MD's. Workshop, Oct. 8-19, La Crosse, WI. Sponsor: Exercise Program—University of WI—La Crosse, Workshop Unit, Mitchell Hall, La Crosse, WI 54601. Cosponsors: Gunderson Clinic, Ltd., International Medical Education Corp., La Crosse Lutheran Hospital, Skemp Grandview Clinic, St. Francis Hospital. Fee: \$350. Reg. limit: 40. Credit: AAFP Prescribed, 43 hours; CEARP, 43 hours; Iowa P.T. Examiners, 35 hours. Contact: Philip Wilson. Phone: 608/785-8687.

Dermatology

Primary Care Dermatology

For: Primary Care Dermatologists. Course, Oct. 5-7, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Fee: \$175. Reg. limit: none. Credit: AMA Category 1, 12 hours. Contact: Patricia McClure. Phone: 312/649-8533.

Emergency Medicine

Eighth Annual Emergency Care Symposium/Cardio-Pulmonary Emergencies

For: MD's. Lecture, Oct. 20, Lafayette, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Financial Planning

Financial Planning for the Future

For: MD's. Lecture, Oct. 19-20, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$82.50. Credit: AMA Category 1, 12 hours. Contact: John Roscoe. Phone: 317/264-8353.

Hypertension/Internal Medicine/ Cardiology

Lake County Medical/Surgical Seminar

For: MD's, DO's, RN's. Symposium, Oct. 24, Waukegan. Speaker: Neil Kurtzman, MD. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan 60085. Reg. deadline: 10/22. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AOA, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Medicine

Carle Foundation Day 1979

For: MD's. Clinical conference/lecture, October 17, Ramada Convention Center, Champaign. Sponsor: The Carle Foundation, 611 West Park St., Urbana 61801. Reg. deadline: 10/10. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Joseph Cleveland, MD. Phone: 217/337-3190.

Medical Photography

Fifth Annual Medical Photography Workshop

For: MD's. Workshop, Oct. 27, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 7 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Diabetes and Metabolic Disease

For: MD's. Symposium, Oct. 6-7, 1:00 p.m., Robinson. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 10 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

NATIONAL HYPERTENSION CONFERENCE

A national conference on the Current State of the Art in High Blood Pressure Control Applied to Rural Communities will meet October 25-27, 1979, in Myrtle Beach, South Carolina. The latest behavioral, epidemiological, and clinical high blood pressure research findings will be presented. Recommendations will be formulated for improving high blood pressure control in rural communities.

For more information, please contact: Mrs. Georgia Wingard, S. C. Dept. of Health and Environmental Control, Division of Chronic Disease Control, 2600 Bull St. Columbia, S. C. 29201.

Medicine

Common Lower Gastrointestinal Tract Disorders

For: MD's. Symposium, Oct. 4, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Problems and Concepts of Care for Terminally Ill

For: MD's, RN's, hospital administrators. Course, Oct. 19, Continental Plaza Hotel, Chicago. Sponsor: Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60604. Credit: AMA Category 1, 8 hours; AOA, 8 hours. Contact: Louis Kuhn. Phone: 312/944-5144.

Medicine

Seventh Annual Weber Clinic Medical Conference

For: MD's. Conference, Oct. 27, 12:30 p.m., Olney. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Immunology

For: MD's. Symposium, Oct. 23, 7:00 p.m., Vandalia. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Nephrology

Nephrology Update

For: primary care physicians. Lecture/panel, Oct. 5, Terre Haute, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Neuro-Ophthalmology

Clinical Neuro-Ophthalmology

For: Ophthalmologists, Neurologists, Neuro-Surgeons. Lecture, Oct. 18, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Division of CME, 1100 W. Michigan St., Indianapolis 46223. Fee: \$50. Credit: AMA Category 1, 6 hours. Contact: John Roscoe. Phone: 317/264-8353.

Office Management

Choosing and Using a Computer in a Private Medical Practice

For: MD's. Lecture/workshop, Oct. 26-27, Chicago. Sponsor: University of Health Sciences/Chicago Medical School, 2020 W. Ogden Chicago 60612. Fee: \$195. Reg. limit: 50. Credit: AMA Category 1, 18 hours. Contact: Ben Blivaiss. Phone: 312/942-2965.

Primary Care

Cardiac Rehabilitation

For: GP's, Internists, Lectures/workshops, Oct. 26-28, Water Tower Hyatt House, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Surgery

Head & Neck Cancer: New Development in Diagnosis & Treatment

For: MD's. Symposium, Oct. 19-20, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 13 hours; AAFP Elective, 13 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Surgery & Medicine

Infectious Disease

For: MD's. Symposium, Oct. 10, 8:00 a.m., Holiday Inn East, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P O Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 8 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

November

New Horizons—1980

For: MD's. Symposium, Nov. 14, The Drake Hotel, Chicago. Sponsor: American Diabetes Association, Northern Illinois Affiliate, 620 No. Michigan Ave., Chicago 60611. Reg. deadline: 11/9. Fee: \$15, members; \$25, nonmembers. Credit: AMA Category 1, 4½ hours. Contact: Florence Narodick. Phone: 312/943-8668.

Family Medicine

Standards of Eye Care for the Primary Physician

For: General Practice, Emergency Medicine. 2-day seminar, Nov. 29-30, Chicago. Sponsor: U of I at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: none. Fee: \$150. Credit: AMA Category 1, 14 hours. Contact: Jane Whitener. Phone: 312/996-8025.

Family Medicine

Management of the Acute Cardiac Patient

For: FP's. Lecture, Nov. 28 (3 days), Chicago. Speaker: Kenneth Rosen, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$175. Reg. limit: 75. Credit: AMA Category 1, 21 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

NEW ACCREDITATION MANUAL AVAILABLE

On behalf of ISMS, ICCME has published the third edition of the official accreditation manual: ACCREDITATION OF CONTINUING MEDICAL EDUCATION IN ILLINOIS. While addressed primarily to CME Planners/Committees, Accreditation Surveyors, and medical leadership, it also constitutes a short "textbook" on CME planning for general use.

Copies are FREE to Illinois physicians and CME Planners. To order, write or call, ICCME, 55 E. Monroe, Suite 3510, Chicago, IL 60603. Telephone: 312/236-6110.

Primary Care

105th Annual Meeting of Southern Illinois Medical Association

For: MD's. Course/lectures, Nov. 8, 8:00 a.m., Fischer's Restaurant, Belleville. Sponsor: Southern Illinois Medical Association. Fee: none. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Dale Rosenberg, MD, Suite 3-E, 6401 W. Main St., Belleville 62223. Phone: 618/398-5600.

Internal Medicine

Pneumonia—Diagnosis, Treatment, Prevention

For: MD's. Lecture, Nov. 14, 11:00 a.m., Chicago. Speaker: Charles Helms, MD. Sponsor: Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618. Cosponsor: Merck Sharp & Dohme. Reg. limit: none. Fee: none. Credit: AMA Category 1, 1 hour; AAFP, 1 hour. Contact: Fernando Villa, MD. Phone: 312/583-9000 x 331.

Advances in Medicine

For: Internists. Lecture, Nov. 5 (5 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$225. Reg. limit: 100. Credit: AMA Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Basic Neurological Examination

For: MD's. Symposium, Nov. 2, 11:15 a.m., Oak Park. Speaker: Jordan Tapel, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

How to Use the Mental Status Examination

For: MD's. Symposium, Nov. 9, 11:15 a.m., Oak Park. Speaker: Ralph Pagano, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

Alzheimer's Disease—Diagnosis and Treatment

For: MD's. Symposium, Nov. 16, 11:15 a.m., Oak Park. Speaker: Bernard Kirk, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

The Comatose Patient—Diagnosis and Treatment

For: MD's. Symposium, Nov. 30, 11:15 a.m., Oak Park. Speaker: L. I. Yarzagaray, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Obstetrics

Evaluation & Management of the Infertile Couple

For: GP's, Obstetricians. Lecture, Nov. 14, 1:30 p.m., Chicago. Speaker: George Morulis, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Otolaryngology

7th Course in Clinical Neurotology

For: Otolaryngologists. 4-day seminar, Nov. 5-8, Chicago. Sponsor: U of I at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: none. Fee: \$300. Credit: AMA Category 1, 28 hours. Contact: Jane Whitener. Phone: 312/996-8025.

Hypertension

December

Family Medicine

Standards of Eye Care for the Primary Physician: Geriatric Ocular Disorders

For: GP's, Emergency Medicine. Seminar, Dec. 13-14, Chicago. Sponsor: University of Illinois at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: none. Fee: \$150. Credit: AMA Category 1, 14 hours. Contact: Jane Whitener. Phone: 312/996-8025.

Neurology

Multiple Sclerosis and Syringomyelia—Diagnosis and Treatment

For: MD's. Symposium, Dec. 7, 11:15 a.m., Oak Park. Speaker: Robert Tentler, MD. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Neurology

Myasthenia Gravis—Diagnosis and Treatment

For: MD's. Symposium, Dec. 14, 11:15 a.m., Oak Park. Speaker: K. McCoy, M.D. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

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EKG

(Continued from page 153)

Answers: 1. D 2. E

The first two beats of the rhythm strip in line one are sinus beats followed by a burst of multifocal atrial tachycardia. The rate of the tachycardia is approximately 150 beats per minute. A close examination of the non-sinus P waves shows a series of different P wave contours, PR intervals, and changing R-R cycles. Variable P wave morphology, P-P cycles, R-R cycles, PR intervals with a rapid rate make a diagnosis of multifocal or chaotic atrial tachycardia. Over 50% of these cases will be preceded or followed by atrial fibrillation or flutter. In line three, a series of P waves at a rate of 375 beats/minute with 2:1 atrioventricular block are seen—atrial flutter. ST segment deviation is present in all beats as a result of the acute infarction. The incidence of supraventricular tachycardias varies with the exact atrial arrhythmia: atrial tachycardia 4-8%, atrial flutter 1-2%, and atrial fibrillation is the

most common at 6-16%. When these arrhythmias are seen in the presence of acute myocardial infarction, atrial infarction is often suspected but frequently is hard to prove. Hemodynamically, the rapid rates of these tachycardias increase myocardial oxygen demands in an already impaired myocardium. Digitalis is the treatment of choice unless the tachycardia causes a worsening of the patient's hemodynamic status. Then direct current cardioversion is recommended. Atrial flutter can be particularly difficult to manage medically and often requires D.C. cardioversion. Fortunately, atrial flutter often converts at low energy levels. Our patient required both treatment approaches. Overall mortality seems to be related to the underlying myocardial pathology. For further reading on this topic see Liberthson, *et al.*, *American Journal of Medicine*, 60:956-960, 1976. ◀

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Clinics for Crippled Children Listed for November

Thirty-six clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 26 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Nov. 1 Lake County Cardiac—Victory Memorial Hospital
- Nov. 1 Sterling—Community General Hospital
- Nov. 1 Pittsfield—Illini Community Hospital
- Nov. 1 Effingham—St. Anthony Memorial Hosp.
- Nov. 2 Division Cardiac—U. of I. at the Medical Center
- Nov. 6 Belleville—St. Elizabeth's Hospital
- Nov. 6 Park Ridge Cardiac—Lutheran General Hospital
- Nov. 7 Hinsdale—Hinsdale Sanitarium
- Nov. 7 DuQuoin—Marshall Browning Hospital
- Nov. 8 Springfield General—St. John's Hosp.
- Nov. 8 Macomb—McDonough District Hosp.
- Nov. 9 Chicago Heights Cardiac—St. James Hospital
- Nov. 12 Peoria Cardiac—St. Francis Hospital
- Nov. 13 Anna—Union County Hospital
- Nov. 13 East St. Louis—Christian Welfare Hosp.
- Nov. 13 Peoria General—St. Francis Hospital
- Nov. 14 Chicago Heights General—St. James Hospital
- Nov. 14 Champaign-Urbana—McKinley Hosp.
- Nov. 14 Springfield Ped-Neuro—St. John's Hosp.
- Nov. 14 Centralia—St. Mary's Hospital
- Nov. 14 Joliet—St. Joseph's Hospital
- Nov. 14 Rockford—St. Anthony's Hospital
- Nov. 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Nov. 16 Chicago Heights Cardiac—St. James Hospital
- Nov. 16 Kankakee Cardiac—St. Mary's Hospital
- Nov. 19 Maywood—Loyola Medical Center
- Nov. 20 Decatur—Decatur Memorial Hospital
- Nov. 20 Rock Island General—Moline Public Hospital
- Nov. 20 Maryville—Oliver C. Anderson Hosp.
- Nov. 21 Evergreen Park—Little Company of Mary Hospital
- Nov. 26 Peoria Cardiac—St. Francis Hosp.
- Nov. 27 Alton—Alton Memorial Hospital
- Nov. 27 Danville—Lake View Hospital
- Nov. 27 Peoria General—St. Francis Hosp.
- Nov. 28 Chicago Heights Gen.—St. James Hosp.
- Nov. 28 Elgin—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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The stress-secretion relationship in duodenal ulcer*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.²



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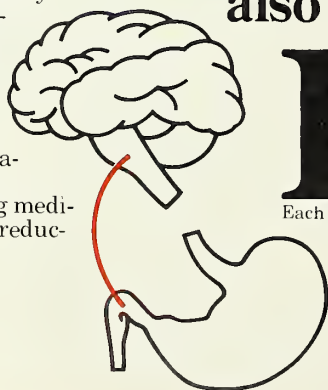
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tion of accompanying anxiety and emotional tension.

References: 1. Isenberg J, Richardson CT, Fordtran JS. Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

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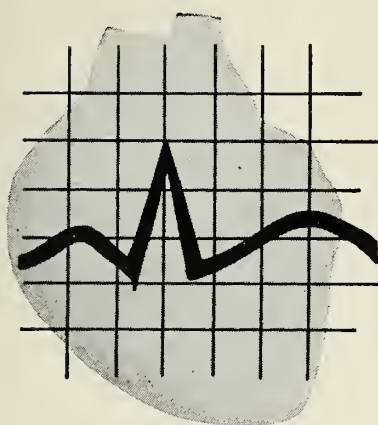
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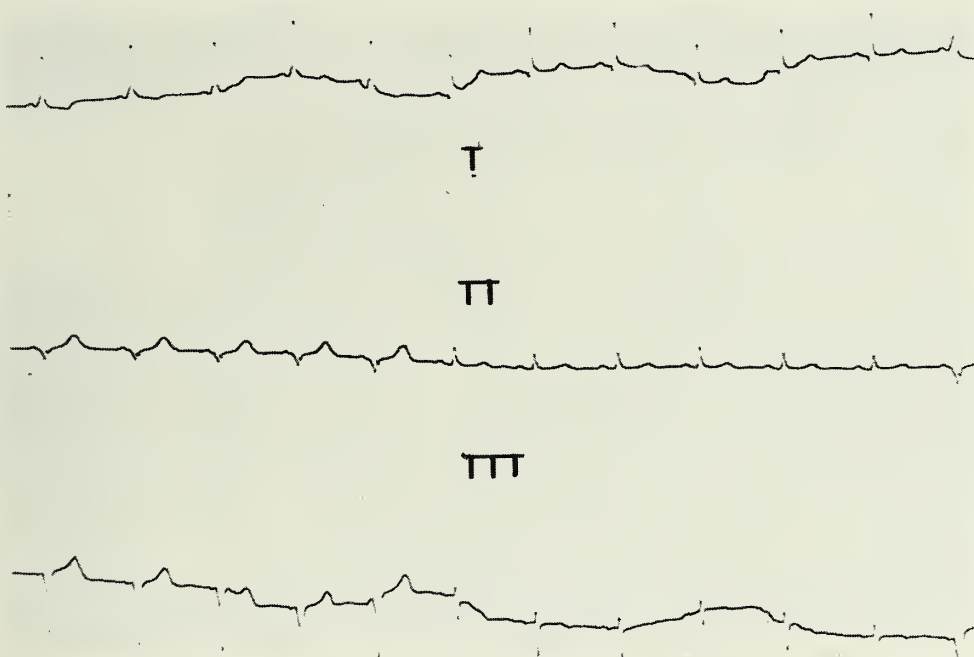
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Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This patient is a sixty-three year old black female who presents with complaints of pruritis ani, rectal pain, and occasional small amounts of mucous and red blood on her undergarments. She also has noted blood on the toilet tissue after a bowel movement. Adult onset diabetes had been diagnosed two years earlier. On physical examination, the heart and lungs were normal. The abdomen was normal. Vaginal examination demonstrated semi-white exudates which subsequently cultured trichomonas vaginitis. The anus, perianal and perivaginal areas were erythematous and tender to touch. There were numerous small ulcerative lesions noted. Surgery was planned. The simultaneous lead I, II, III rhythm strip was obtained.



Questions:

1. The simultaneous lead I, II, III rhythm strip shows:

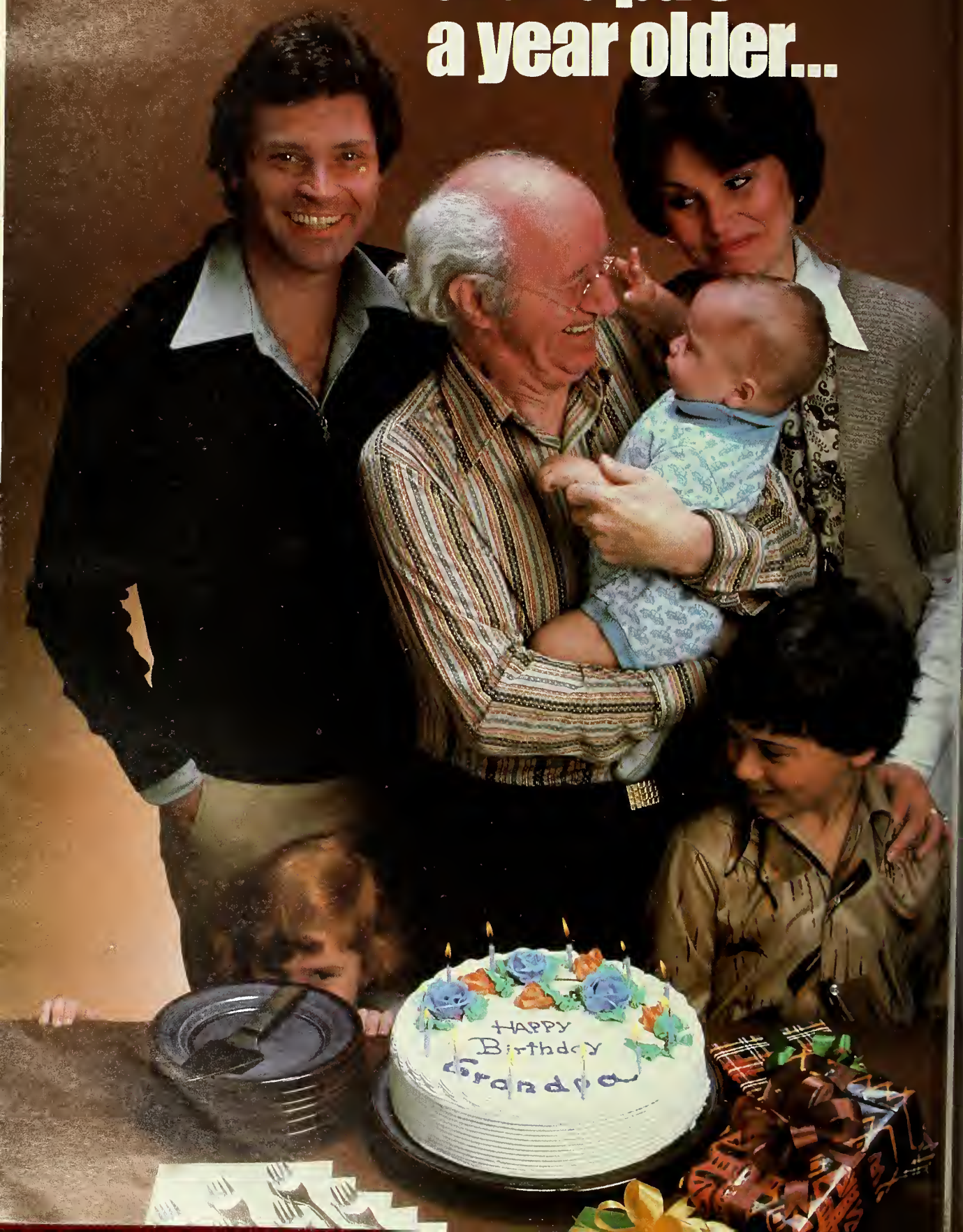
- A. Cycle dependent left bundle branch block.
- B. Cycle dependent left anterior hemiblock or marked left axis deviation.
- C. Recent inferior wall myocardial infarction.
- D. Intermittent Wolff-Parkinson-White syndrome.
- E. None of the above.

2. The following statement(s) is/are true:

- A. The proposed surgery, anal fissurectomy, should be cancelled.
- B. The patient should be admitted to the coronary care unit for observation and ECG monitoring.
- C. The ECG findings have an ominous prognosis.
- D. The proposed surgery should be done.
- E. All but D above.

(Continued on page 218)

Grandpa's a year older...



and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years—

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged. Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate—despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic broncho-pulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease*; *persons in chronic care facilities*.

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

NEW... single-dose, prefilled
disposable syringe for greater accuracy
and convenience

More than ever he may need

PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent | MSD)

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Please see following page for
summary of prescribing information.

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PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent)(MSD)

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature		Pneumococcal Types													
U.S.	1 2 3 4 6 8 9 12 14 19 23 25 51 56														
Danish	1 2 3 4 6A 8 9N 12F 14 19F 23F 25 7F 18C														

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported. Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. **DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.**

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe

Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials

For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

J9PX12 (DC 7014803)

MSD

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For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

Obituaries

***Christiansen, Henry**, Oak Lawn, died August 10, 1979, at the age of 92. Dr. Christiansen was a 1913 graduate of Bennett Medical College in Chicago.

***Dulin, Theodore J.**, Chicago, died July 14, 1979, at the age of 66. Dr. Dulin was a 1938 graduate of the University of Illinois.

***Kopstein, Geza G.**, Evanston, died August 12, 1979, at the age of 79. Dr. Kopstein was a 1925 graduate of Wren Medical College in Austria.

***Maxon, Earl Dwight**, Sarasota, Florida, formerly of Western Springs, died August 27, 1979, at the age of 91. Dr. Maxon was a 1918 graduate of the Loyola University Stritch School of Medicine.

***Reid, Prentis Edgar**, Sparta, died August 19, 1979, at the age of 82. Dr. Reid was a 1935 graduate of Northwestern University Medical School.

***Sherman, Irene C.**, Oak Park, died August 23, 1979, at the age of 85. Dr. Sherman was a 1932 graduate of Rush Medical College.

***Stone, Joseph George**, Cicero, died August 25, 1979, at the age of 72. Dr. Stone was a 1936 graduate of the Loyola University Stritch School of Medicine.

***Wajay, Louis A.**, Chicago, died August 19, 1979, at the age of 70. Dr. Wajay was a 1939 graduate of the Chicago Medical College.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500.

Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg**, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.

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Illinois Well-Represented At 1979 Annual RPS Meeting

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey Holt, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

Illinois residents played an active role in the 1979 Annual RPS meeting in Chicago. Illinois residents were active in floor discussion, elections and reference committees. Immediate past-chairman of the ISMS-RPS, Ira Isaacson, won the Governing Council position of member-at-large.

AMA-RPS meetings are held in conjunction with and one day prior to the annual (June or July) and interim (December) Meetings of the AMA. A restructured format for the RPS meeting was initiated this year; the meetings started on Friday evening rather than Friday morning with the bulk of the meeting during the day Saturday. This rearrangement should make it easier for residents in standard residency programs to participate fully.

Illinois residents who participated in the meeting were: Bret Cassens, Illinois Masonic; James DeBord, Peoria; William Golden, Rush Pres.-St. Lukes; Barry LeCompte, Rush Pres.-St. Lukes; Larry Gratkins, Northwestern University; David Olive, Northwestern University; Kimberly Johnson, Northwestern University; Ira Isaacson, Northwestern University (now Massachusetts); Linda Hughey-Holt, University of Chicago; Anne Nunnally, University of Chicago; and Scott Karl, Champaign-Urbana.

Council on Scientific Affairs: Residents Report

Illinois physician James DeBord, M.D., has served as resident member on the AMA Council on Scientific Affairs (CSA) for two years. Dr. DeBord reported on the activities of the CSA at the July annual meeting.

Issues of specific interest to residents which have involved RPS proposals are marijuana and tobacco smoking. The CSA is in process of reviewing data on marijuana use. The 1977 AMA policy statement on marijuana use is being revised in light of new knowledge of therapeutic uses and the effects of herbicide (paraquat) on consumers of marijuana. CSA is also reviewing the AMA policy on cigarette smoking. The RPS

has been involved in both of these issues through the RPS representative assembly and through the resident Council representative.

Other areas covered by the Council on Scientific Affairs include alcoholism, physical fitness, nutrition, propoxyphene reclassification, and effects of nuclear power on health. Copies of Dr. DeBord's report may be obtained from the AMA Department of House Staff Affairs, 535 N. Dearborn, Chicago 60610.

Secretary-Editor's Comment — Why Bother?

As we contemplate our 100 hour work week, our lack of time for recreation, our lack of time for our families, and our growing stacks of unread journals, each of us often wonder why we bother with medical society activities at all. Many residents feel that they are unlikely to affect national policy and furthermore find themselves miles apart politically from regular AMA and ISMS members. The medical profession in which we are going to be practicing will probably be worlds apart from the present patchwork of fee-for-service, medicare/medicaid, HMO's and third-party insurers.

Those of us who participate in ISMS and AMA activities do so for a wide variety of reasons, but we all share three basic desires. First is the desire to *learn* about legislation and legal decisions which will soon affect our lives. If we take time to read our legislative and judicial reviews from the ISMS, we at least know what changes are occurring. Secondly, we desire to meet and to share ideas with other individuals who realize that the practice of medicine involves more than day-to-day doctor-patient contact. Thirdly, we all hope in some way to affect the future of medical practice. Whether we desire a nationalized health care system or a complete return to a fee-for-service system (and *both* views are represented within the medical society) we hope that as physicians working together we may develop a health care system which will best serve the American people. ◀

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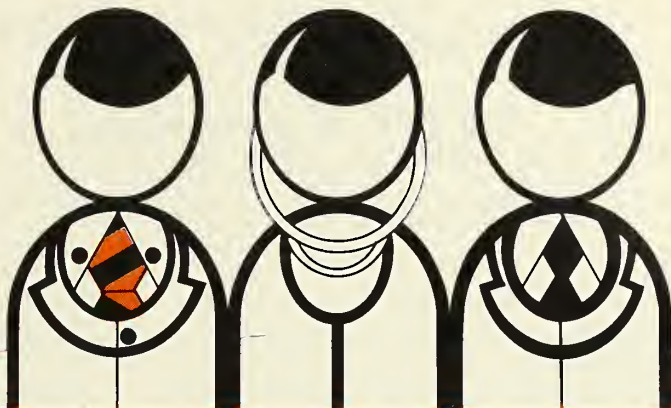
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Student Business Session in Action

SBS/ISMS Fall/Winter 1979 Educational Seminar

Twice annually, the Student Business Session of ISMS sponsors educational seminars open to the public. These are intended to provide current information on important health care issues to interested members of the community and medical professionals. For fall/winter 1979, we are presenting an especially timely seminar entitled "Government in Health Care: How Much is Enough?"

Speakers will be asked to evaluate the impact on consumer and professional of increasing federal involvement in the provision of health care. Given the diverse backgrounds and viewpoints of our scheduled speakers, the question-and-answer session to follow the formal presentation should be lively.

At this time, we have recruited the following distinguished experts on health care policy:

1. John Neuman, Ph.D., Senior Director of Research and Evaluation, Blue Cross and Blue Shield.
2. Quentin Young, M.D., Chairman, Department of Medicine, Cook County Hospital.

3. Richard Foster, Ph.D., Associate Director, Health Services Administration Research Center, University of Chicago Graduate School of Business.

4. Howard Bunan, Vice President, American Hospital Association.

In addition, we have asked Illinois Congressman Paul Simon to speak. He has shown a great deal of interest in health care issues and has recently introduced legislation pertaining to National Health Insurance. If he is unable to attend due to scheduling conflicts, we shall seek the services of another Congressman or health care policy staff worker.

The seminar will be held Saturday, November 17, 1:00 p.m.-5:00 p.m. at the Chicago Pick Congress Hotel. Refreshments will be provided. Detailed announcements will be posted at all Illinois medical schools and business schools. Hour-for-hour Category 2 CME credit is available to participants.

David H. Whitney, Fall/Winter
1979 education seminar chairman

Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400^{TABLETS}mg
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin: used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

EKG

(Continued from page 203)

Answers: 1 D. 2 D.

The first five beats and the last beat in the rhythm strip show sinus rhythm with a short PR interval of 0.10 second, an initial QRS slurring—the delta wave, and a prolonged QRS duration. This is intermittent Wolff-Parkinson-White syndrome (WPW). There is slight sinus arrhythmia but it cannot be considered a cycle dependent phenomenon. The WPW syndrome is frequently diagnosed as an incidental finding on the ECG. The vast majority of cases in the adult population have this as an isolated finding. Approximately one-third of patients will have associated heart disease. About 5-10% of patients with paroxysmal supraventricular tachycardias will have the WPW syndrome. The prevalence of WPW in adults is reported to be 0.155%. Left axis deviation is also a commonly associated finding but is probably not left anterior hemiblock. The WPW syndrome can frequently be mistaken for inferior or anteroseptal myocardial infarction. Our patient had the WPW syndrome as an incidental finding. There was no incidence of heart disease and no history of palpitations. She had the anal fissurectomy without complications and did well post-operatively. For further reading on this interesting subject see Sherf and Neufeld. *The Pre-Excitation Syndrome: Facts and Theories*. Yorke Medical Books, 1978. ◀

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professional liability
insurance program

**The Exchange is preparing to redeem Guaranty Fund
Certificates held by retired physicians and the estates
of deceased physicians.**

Last year the Illinois Department of Insurance allowed the Exchange to change the order of redemption of Guaranty Fund Certificates, giving priority to Certificates held by retired physicians and the estates of deceased physicians. This authorization was qualified by the long standing requirement that redemption must be made from earned surplus. In its March 1979 Financial Statement, the Exchange reported an earned surplus for the

first time. Enough funds have now been accumulated to begin this redemption.

Eligible physicians and estates will receive notice by mail. If you think you are eligible for redemption, or know someone who might be, and you do not receive notice, please call an ISMIS Communication Services Counselor at 312/782-1654.

Remember: A Certificate cannot be redeemed if it is being used to secure an in-force policy.

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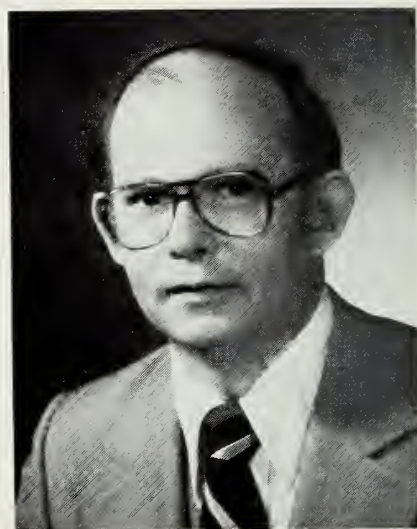
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President's Page

"A sect or party is an elegant incognito devised to save man the vexations of thinking."

Ralph Waldo Emerson



The Vexations of Thinking

Physicians seem to demonstrate a reluctance to participate in the political process. On the surface this is understandable. It seems foolhardy to immerse ourselves in a system that nurtures a bureaucracy responsible for major problems confronting our profession.

It is impossible to dispute the fact that non-participation is cheap and easy. In addition, it does not jeopardize the right to complain. That is important. Lamenting government's unscientific approach to health care problems soothes our consciences and generates a sense of accomplishment. But non-participation also carries a monumental liability: it does nothing to temper government's efforts to control health care.

The political process is the basis of our country's philosophy that the majority will rule. The two party system allegedly gives that majority a choice of approaches to key issues. But the similarity of these parties — coupled with government's inertia — makes it convenient for physicians to either shun the process or "hide" within the party structure. Non-participation allows government to proceed with programs that jeopardize patient care. The alternative is to support candidates — regardless of party affiliation — who embrace medicine's viewpoint. Unfortunately, this option frequently is rejected as being too demanding and complex.

Nothing could be further from the truth. The Illinois Medical Political Action Committee (IMPAC) evaluates candidates . . . and by joining IMPAC, you are "selectively" participating in the political process and also helping to shape our profession's future.

We must endure the "vexations of thinking" demanded by participation in the political process. ◀

P. John Seward, M.D., President

Doctor's News

PHYSICIANS IN THE NEWS—Mark W. Dreyer, M.D., is the 1979 recipient of the Norris L. Brookens Award of the Illinois Society of Internal Medicine (ISIM). The award is given annually to a third-year resident physician, in honor of the late Dr. Brookens, charter ISIM member and its first president. . . . Eugene Diamond, M.D., Palos Park, professor and assistant chairman of the department of Pediatrics at the Loyola University Stritch School of Medicine, has been installed as president of the National Federation of Catholic Physicians' Guilds. . . . Chicago physician Lonnie C. Edwards, M.D., was recently elected a regional delegate to the American Hospital Association House of Delegates. . . . William J. Grove, M.D., Hinsdale, has announced that he will resign as vice chancellor for academic affairs at the UI Medical Center Campus, effective August 31, 1980. In his letter of resignation, Dr. Grove, who plans to remain on the UI faculty, stated that the campus "is entering a new phase of evolution that requires a perspective different from that I helped to bring into focus 10 or more years ago."

CHC RELEASES STUDY—"Government Underpayment of Metropolitan Chicago Hospitals: Parts A and B," is the title of a recently released report from the Chicago Hospital Council. According to their release, the study shows that: (1) Chicago-area community hospitals received less than full financial requirements from governmentally funded third party payers in 1977; (2) average charges to private-pay and commercial insurance pay patients would have had to include nearly \$23 per patient day extra in order to fully compensate for that; and (3) hospitals unable to increase charges to cover these underpayments were not able to meet their financial requirements through operating revenue. According to the report, those hospitals could, over a period of time, incur severe financial difficulties similar to those described in the CHC "Endangered Hospital Study," of 1977. Ultimately, this could lead to depletion of reserves or reductions in service.

SMOKING DURING PREGNANCY—is the target for a series of grants available from the Pregnancy and Perinatology Section, Center for Research for Mothers and Children, National Institute of Child Health and Human Development. Grants in aid are available on a competitive basis to non-profit institutions interested in initiating research studies on the epidemiologic, biologic and pharmacologic facets of cigarette smoking during pregnancy, and its impact on fetal and infant health. Further information may be obtained from Dr. Charlotte Catz at the office of the Institute in Bethesda, Maryland 20205. Telephone: (301) 496-1485.

IN A RELATED NOTE—The Illinois Interagency Council on Smoking and Disease has announced that National No-Smoking Day will be held this year on November 15. Promotional posters, etc., may be obtained from the American Cancer Society, 37 S. Wabash Ave., Chicago 60603.

GENITAL HERPES TREATED SUCCESSFULLY—A recent issue of *JAMA* announced results of a study reported by Herbert A. Blough, M.D., of the University of Pennsylvania. The reported experiments involved treatment of genital herpes simplex infection patients with 2-deoxy-D-glucose. The 36 women treated for a three-week period had a first infection cure rate of 95%, and 90% rate of notable improvement in those with recurrent infection. In first infection cases, discomfort reportedly cleared within 12-72 hours of therapy, and 90% of those patients were free of symptoms in four days.

INTRAV ANNOUNCES JANUARY TOUR—An INTRAV "South American Adventure" is scheduled for January 15 through January 26, 1980. More information about the itinerary, which includes visits in Peru and Ecuador during their summer season, may be obtained from the ISMS offices.

MEDICAL REVIEW PROGRAMS ANNOUNCED—The Center for Health Sciences at Oakland University in Rochester, Michigan offers semiannual review programs for persons preparing to take the FLEX, ECFMG and VQE examinations. Students are registered as full-time graduate students at the university and receive 16 academic credits for the course, which provides an intensive 12-week review of the basic and clinical sciences, as well as patient management problems, with an emphasis on clinical relevance. Tuition and fees at present are \$623.00. Further information is available from Arthur J. Griggs, Assistant to the Director, Center for Health Sciences, Oakland University, Rochester, MI 48063.

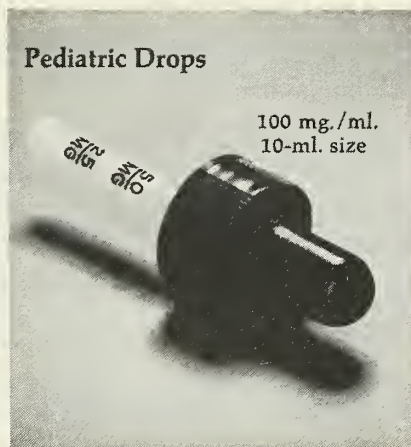
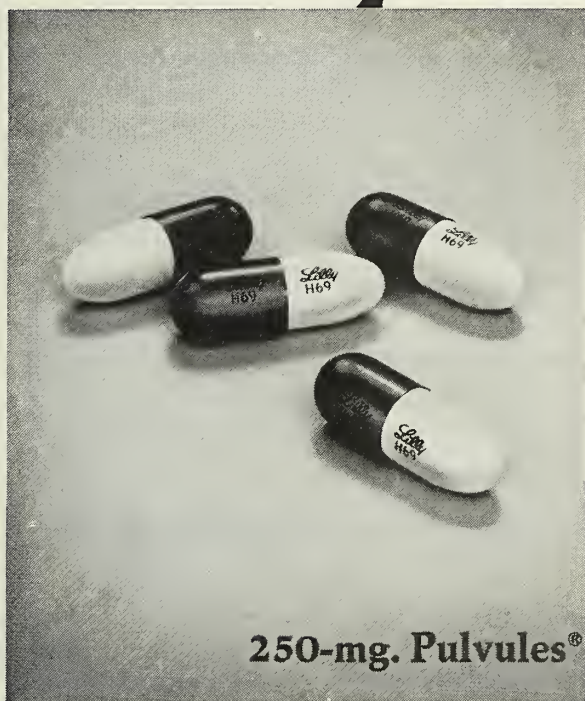
MEDICAL MARIJUANA—The Illinois Dangerous Drugs Commission has announced that physicians may now obtain authorization to administer and dispense cannabis for treatment of chemotherapy side effects in cancer patients. Interested physicians, who must be licensed by the DDC and comply with an investigative protocol, may obtain information packets and forms for licensure by contacting Mr. Robert Stachura, Chief of Licensing, Dangerous Drugs Commission, 300 N. State Street, Suite 1500, Chicago 60610.

ANTIVENIN INDEX AVAILABLE—The Antivenin Committee of the American Association of Zoological Parks and Aquariums, in cooperation with the Oklahoma Poison Control Center at Oklahoma Children's Memorial Hospital, has completed publication of the National Antivenin Index for 1978-79. The index can be obtained for \$3.00 by writing the Poison Control Center at P.O. Box 26307, Oklahoma City, OK 73126. Information regarding location of serum for therapeutic use is available 24 hours per day by telephone at the center. (405) 271-5454.

HISTORY OF MEDICINE BIBLIOGRAPHY AVAILABLE—KTO Press, Liechtenstein, is planning to publish the subject catalogue of the renowned Wellcome Institute for the History of Medicine. The catalogue, a comprehensive guide to secondary literature on the history of medicine, will be published in three sections. The first section, comprising eight volumes, is now available. Further information on the "Subject Catalogue of the History of Medicine & Related Sciences," may be obtained by writing KTO Press, FL-9491 Nendeln, Liechtenstein.

PAGET'S DISEASE FOUNDATION FORMED—A national, nonprofit organization dedicated to improving health care for people suffering from Paget's Disease of Bone recently announced incorporation. The Foundation reported that they seek to bring information about progress in the treatment of the disease of patients, raise doctors' interest in the study and treatment of Paget's disease, and support education and research for the advancement of therapy for Paget's disease of Bone. Physicians are urged to advise their patients about the organization, which can be reached at its principal office, 325 Engle Street, Tenafly, New Jersey, (201) 567-0665.

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“I Quit” Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of “I Quit Smoking” clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

October 29	Lutheran General Hospital	Park Ridge
November 5	YWCA	Rockford
November 5	Christ Hospital	Oak Lawn
November 6	Daley Center	Chicago
November 11	Seventh Day Adventist Church	Hinsdale
November 11	Victory Memorial Hospital	Waukegan
November 13	Holy Cross Hospital	Chicago
December 3	Palatine Park District and Library	Palatine
December 4	Daley Center	Chicago
January 2	Highland Park Hospital	Highland Park
January 8	South Suburban Hospital	Hazelcrest

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Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

November

Acute Care

G.I. Bleeding and Endoscopy

For: MD's. Dinner/lecture, Nov. 27, 6:00 p.m., Highland Park. Speaker: Charles Winans, MD. Sponsor: Highland Park Hospital, 718 Glenview Ave., Highland Park 60035. Fee: \$10. Reg. limit: 60. Credit: AMA Category 1, 1 hour. Contact: Arnold Goldstein, MD. Phone: 312/432-8000 x 4000.

Family Medicine/Surgery

Lake County Medical/Surgical Seminar

For: MD's, DDS's, RN's. Seminar, Nov. 28, 8:00 a.m., Waukegon. Sponsor: St. Therese Hospital, 2615 Washington, Waukegon 60085. Reg. deadline: 11/26. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AOA Category 2, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Family Therapy

Marital Conflict: Integrative Approach

For: MD's. Workshop, Nov. 3, 9:00 a.m., Chicago. Speaker: Lorry Feldman, MD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$45. Reg. limit: 100. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Family Therapy

Paradoxical Techniques in Family Therapy

For: MD's. Workshop, Nov. 15, 9:30 a.m., Chicago. Speaker: Robert Mark, PhD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$45. Reg. limit: 100. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Hormone Immunoassay

Medical Applications of Hormone Immunoassay

For: Internists, Endocrinologists, Pediatricians, Technicians. Lecture, Nov. 8-9, Clinical Science Center, Madison, WI. Sponsor: University of WI—Extension, CME Dept., 465b WARF Bldg., 610 Walnut St., Madison, WI 53706. Cosponsor: University of WI-Madison. Fee: \$100. Reg. limit: 50. Credit: AMA Category 1, 13 hours. Contact: Sorah Aslaksen. Phone: 608/263-2856.

Internal Medicine/Family Practice

Update in Selected Topics in Medicine

For: MD's. Symposium, November 29-30, St. Luke's Hospitals, St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Cosponsor: St. Luke's Hospitals. Fee: \$150. Reg. limit: 200. Credit: AMA Category 1, 12 hours; AAFP Prescribed, 12 hours. Contact: Loretta Giacometti. Phone: 314/367-9673.

Medicine

Thromboembolic Disease Symposium

For: MD's. Symposium, Nov. 29, 1:00 p.m., Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

The Battered and/or Neglected Child

For: MD's. Symposium, Nov. 8, 7:00 p.m., Mt. Vernon. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours; AAFP Prescribed, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Thyroid Diseases/Ovarian Disease

For: MD's. Symposium, Nov. 28, 6:00 p.m., Alton. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Adult and Pediatric Problems in Renal Disease

For: MD's. Symposium, Nov. 15, 9:00 a.m., East St. Louis. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Blood Gases

For: MD's. Symposium, Nov. 15, 7:00 p.m., Effingham. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours; AAFP Prescribed, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Metabolic Disorders Symposium

For: MD's. Symposium, Nov. 8, 1:00 p.m., Pittsfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Legal Aspects of Medical Practice

For: MD's. Symposium, Nov. 7, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Clinical Immunology Symposium

For: MD's. Symposium, Nov. 1, 2:00 p.m., Lincoln. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours; AAFP Prescribed, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Diabetes

For: MD's. Symposium, Nov. 1, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$30 (includes dinner). Credit: AMA Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Obstetrics/Gynecology

Hysteroscopy—Fundamentals and Recent Advances

For: Obstetricians, Gynecologists. Course, Nov. 16, 8:00 a.m., Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Cosponsor: Prentice Women's Hospital and Maternity Center. Fee: \$150. Reg. limit: none. Credit: AMA Category 1, 6 hours. Contact: Lori Dorfler. Phone: 312/649-8536.

Orthopaedics

Office Orthopaedics

For: primary care, FP's. Course, Nov. 28, 8:00 a.m., Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan St., Indianapolis, IN 46223. Fee: \$60. Reg. limit: none. Credit: AMA Category 1, 7 hours; AAFP Prescribed, 7 hours. Contact: John Roscoe. Phone: 317/264-8353.

Pathology

Laboratory Update—1980

For: Pathologists. Course, Nov. 9, 8:00 a.m., Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan St., Indianapolis, IN 46223. Fee: \$60. Reg. limit: none. Credit: AMA Category 1, 8 hours; AAFP Prescribed, 8 hours. Contact: John Roscoe. Phone: 317/264-8353.

Pediatrics

Fall Pediatric Day: Adolescent Medicine Today

For: Pediatricians, FP's. Lecture/workshop, Nov. 9, Madison, WI. Sponsor: University of WI—Extension, CME Dept. and University of WI—Madison, School of Medicine, 465b WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$45. Reg. limit: 200. Credit: AMA Category 1, 7 hours; AAP, 7 hours. Contact: Sorah Aslaksen. Phone: 608/263-2856.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Nov. 14, 1:00 p.m., Forest Park. Speaker: Frank Farrelly, ACSW. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park, 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Psychiatry

Recent Advances in Geriatric Psychiatry

For: MD's. National conference/workshop, Nov. 2-3, Holiday Inn City Centre, Chicago. Sponsor: Rush Medical College, Dept. of Psychiatry, 600 S. Paulina, Chicago 60612. Reg. deadline: 10/29. Fee: \$125. Credit: AMA Category 1, 10 hours. Contact: Harold Paul, MD. Phone: 312/942-6917.

Socio-economic

Presentation by President of ISMS, Dr. Seward

For: MD's. Lecture, Nov. 21, 12:00 noon, Nordic Hills, Itasca. Speaker: P. John Seward, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard 60148. Reg. limit: none. Fee: none. Credit: AMA Category 2, 1 hour. Contact: Mrs. Lillian Widmer.

December

Family Therapy

Low of Child Abuse and Family Therapists
For: MD's, therapists. Workshop, Dec. 7-8, Chicago. Speaker: Sandra Nye, JD, MSW. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$90. Reg. limit: 100. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Forensic Medicine

Forensic Pathology and Clinical Forensic Medicine

For: MD's, attorneys. Case presentations, every Thursday, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, IL, 1828 W. Polk St., Chicago 60612. Reg. deadline: none. Fee: none. Reg. limit: none. Contact: Robert Stein, MD. Phone: 312/443-5017.

Internal Medicine/Family Practice

Clinical Allergy for Practicing Physicians

For: MD's. Symposium, Dec. 6-8, St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$160. Reg. limit: 150. Credit: AMA Category 1, 15 hours; AAFP Prescribed, 15 hours. Contact: Loretta Giacometti. Phone: 314/367-9673.

Medicine

Orthopaedics (Hand/Wrist/Forearm/Feet)

For: MD's. Symposium, Dec. 5, 1:00 p.m., Nashville. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Lake County Medical/Surgical Seminar

For: MD's, DO's, DDS's, RN's, RPH's. Seminar, Dec. 12, 8:00 a.m., Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan 60085. Reg. deadline: 12/10. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AOA Category 2, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Medicine

Clinical Immunology

For: MD's. Symposium, Dec. 8, 1:00 p.m., Mt. Carmel. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Neurology

Neurology for the Non-Neurologists

For: MD's. Workshop, Dec. 12-14, 8:30 a.m., Sheraton Plaza Hotel, Chicago. Sponsor: Rush University, Office of Continuing Education, 600 S. Paulina, Chicago 60612. Reg. deadline: 12/7. Fee: \$250. Reg. limit: 150. Credit: AMA Category 1, 18 hours. Contact: Harold Paul, MD. Phone: 312/942-7095.

Obstetrics/Gynecology

Annual Course in Colposcopy for the Practicing Physician

For: Gynecologists. Course, Dec. 7-8, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Co-sponsors: Prentice Women's Hospital and Maternity Center. Fee: \$250. Reg. limit: 100. Credit: AMA Category 1, 13 hours. Contact: Lori Dorfler. Phone: 312/649-8536.

Ophthalmology

Contact and Introocular Lens

For: Ophthalmologists. Course, Dec. 1, 8:00 a.m., Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan St., Indianapolis, IN 46223. Fee: \$60. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: John Roscoe. Phone: 317/264-8353.

Primary Care

EKG Interpretation and Arrhythmia Management

For: GP's, Internists. Lectures/workshops, December 7-9, Water Tower Hyatt House, Chicago. Sponsor: International Medical Education Corporation, 64 Inverness Drive E., Englewood, CO 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 15 hours; AOA, 15 hours. AAFP Elective, 15 hours. ACEP, 15 hours. Contact: Stephen Mattingly. Phone: 800-525-8646 x 237.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Dec. 19, 1:00 p.m., Forest Park. Speaker: Jack Mobley, columnist. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Surgery

Specialty Review in Thoracic Surgery

For: General & Cardiothoracic Surgeons. Lecture, Dec. 10-14, Chicago. Speaker: Sidney Levitsky, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 200. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Urology

Specialty Review in Urologic Pathology

For: Urologists. Lecture, Dec. 3-6, Chicago. Speakers: Thomas John, MD; Irving Bush, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$250. Reg. limit: 100. Credit: AMA Category 1, 32 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Alcoholism

Current Concept of Alcoholism

For: GP's, fulltime specialty. Lecture, Jan. 9, 1:30 p.m., Chicago. Speaker: David Lichtenstein, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

January

MEDICINE FOR TODAY

**31st Annual Program
American Academy of
Family Physicians**

Sessions run October, 1979 thru March, 1980. Credit: AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. Fee: AAFP members, \$110; nonmembers, \$125. Courses will be conducted at the following locations:

Belleville—St. Elizabeth's Hospital
Berwyn—MacNeal Memorial Hospital
Beverly—Little Company of Mary Hospital
Centralia—St. Mary's Hospital
Chicago Nearwest—St. Francis Cabrini Hospital
Chicago North—Swedish Covenant Hospital
Chicago Southwest—Christ Hospital
Harvey—Ingalls Memorial Hospital
Hinsdale—Hinsdale Sanitarium and Hospital
Mattoon—Sarah Bush Lincoln Health Center
Melrose Park—Westlake Community Hospital
Park Ridge—Lutheran General Hospital
Peoria—St. Francis Hospital
Rockford—Swedish American Hospital
Rock Island—Rock Island Franciscan Medical Center
Springfield—St. John's Hospital

For complete information contact: IAFP, 1200 Harger Road, Suite 405, Oak Brook, IL 60521. Phone: 312/325-8502.

Clinical Cardiology

Bypass Surgery in Chronic Stable Coronary Artery Disease

For: MD's. Symposium, Jan. 9, 10:45 a.m., Oak Park. Speaker: Milton Weinberg, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Arrhythmias in Coronary Artery Disease

For: MD's. Symposium, Jan. 16, 10:45 a.m., Oak Park. Speaker: John Moran, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Secondary Prevention of Coronary Events

For: MD's. Symposium, Jan. 23, 10:45 a.m., Oak Park. Speaker: Clarence Pagano, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Preoperative Cardiac Evaluation of the Surgical Patient

For: MD's. Symposium, Jan. 30, 10:45 a.m., Oak Park. Speaker: Patrick Scanlon, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Family Therapy

Techniques for Working with Severely Dysfunctional Families

For: MD's. Workshop, Jan. 18, 9:30 a.m., Chicago. Speaker: Froma Walsh, PhD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$45. Reg. limit: 75. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Medicine

Hepatobiliary Disorders

For: MD's. Symposium, Jan. 17, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Infectious Diseases

For: MD's. Symposium, Jan. 31, 1:00 p.m., Carlinville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Jan. 16, 1:00 p.m., Forest Park. Speaker: Paul Wender, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Surgery/Gastroenterology

Disorders of the Esophagus

For: MD's. Symposium, Jan. 11, 10:45 a.m., Oak Park. Speaker: S. Aishabkhoun, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Peptic Ulcers—Diagnosis and Management

For: MD's. Symposium, Jan. 18, 10:45 a.m., Oak Park. Speaker: John Howser, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Management of Upper Gastrointestinal Bleeding

For: MD's. Symposium, Jan. 25, 10:45 a.m., Oak Park. Speaker: Robert Freeark, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

An Invitation from....

John Bailey, M.D.

Associate Professor of Medicine, Indiana University School of Medicine

Robert Baum, M.D., F.A.C.C.

Staff Cardiologist, University of Colorado Medical Center

Michael Longo, M.D., F.A.C.C.

Professor of Medicine, The Chicago Medical School

Jorge I. Martinez, M.D., F.A.C.C.

Professor of Medicine, Louisiana State University Medical School

William Nelson, M.D., F.A.C.C.

Professor of Medicine, University of Kansas Medical Center

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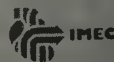
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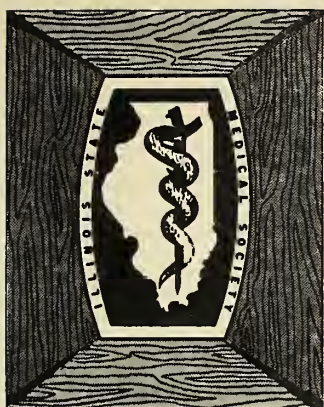
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IMJ

Illinois Medical Journal

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ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers

given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1979

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State

Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principal-

ly in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

- B. Emeritus Members.** Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.
- C. Retired Members.** Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.
- D. Service Members.** Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.
- E. Distinguished Members.** Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.
- F. In-Training Members.** In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.
- G. Student Members.** Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

- A. Tenure of Membership.** The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so

long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

- B. Termination of Membership.** Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have lapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of Dues. Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments and Funds. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and ap-

proved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.

EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, and 8) one delegate elected by the Resident Physicians Section and one delegate elected by the Student Business Session.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Student Business Session, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and it should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose

for which the meeting is called. The meeting shall not consider any business except that for which it was called. Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters four weeks prior to the annual or interim meeting. Resolutions received after the above date except those originating from the RPS or SBS business sessions, must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Resolutions presented from the business meeting of the Resident Physician Section or the Student Business Session may be presented for consideration by the House of Delegates at any time before the close of business of the first day session of the House of Delegates.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. *Judicial Panel.* The House of Delegates shall create a Judicial Panel and shall elect five (5) of its ac-

tive members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The President-Elect.* The president-elect shall serve as the chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at

a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Hender-

son, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive and custodial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board

shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Judicial Panel (Chapter XI of these Bylaws)

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where impartial medical testimony is involved.
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health

5. Licensing and standards of practice

6. Quackery

7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:

1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Internships, residencies, etc.
4. Scientific assembly
5. Student loans
6. Liaison with American Medical Student Association
7. Continuing Medical Education

D. The Council on Economics shall be concerned in the areas of:

1. Ongoing relationships with third parties
2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:

1. The provision of medical care and health services in the public and private sectors
2. Emergency medical services
3. Health care of the poor, aged and those in rural areas
4. Maternal and child health
5. Nutrition
6. Workmen's compensation
7. Environmental and community health
8. Rehabilitation
9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:

1. Publicity and promotion
2. News media relations
3. Exhibits and public service programming
4. Religion and medicine
5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between the affiliate society and ISMS
2. Scientific resource information and advice to ISMS
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation
4. Advances of medical science in special fields
5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society

I. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

J. Peer Review Appeals Committee. This committee

shall conduct all appellate hearings properly filed with it in accordance with Part 2 (D) of Chapter XII of these Bylaws, and shall be responsible to the Board of Trustees for monitoring and evaluating the performance of the peer review functions of the Illinois State Medical Society at all levels.

Section 3. *Organization of Councils.*

- A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
- B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.
- C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Student Business Session and resident physician members nominated by the Governing Council of the ISMS Resident Physician Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.
- D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.
- E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.
- F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.
- G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.
- H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

- I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 - a) as may be approved by the Board of Trustees
 - b) which desire representation on the Council on Affiliate Societies
2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

- A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.
- B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.
- C. Committee on Tellers and Sergeants-at-Arms shall:
 1. Serve the speaker of the House of Delegates.
 2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
 3. Certify those in attendance in closed or executive sessions of the House of Delegates.
- D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.
- E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.
- F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legisla-

tive activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;

3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. The Committee on Third Party Payment Processes shall consist of members of the Board of Trustees and be activated whenever an issue or problem requires high level negotiations between ISMS and third-party payors.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of con-

cern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the per-

sonnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon members of the component societies.

CHAPTER XI. ETHICAL RELATIONS

PART 1. COMPONENT MEDICAL SOCIETY

Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings*.

PART 2. DISTRICT ETHICAL RELATIONS COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee, serving its area, function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relations Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

PART 3. OFFENSES

A. Disciplinary action may be taken against any member of a component society when:

1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
2. He has been adjudged or otherwise recorded as guilty by his component society of:
 - a. acts of serious misconduct as a physician; or

- b. a violation of the Constitution or Bylaws of his component society, or of the Principles of Medical Ethics promulgated by the American Medical Association; or
- 3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

PART 4. STANDARDS AND PROCEDURES

- A. The committee, in its deliberations, shall evaluate acts by the standards established in the Principles of Medical Ethics of the American Medical Association and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.
- B. Disciplinary action may be initiated by the component society or the Illinois State Medical Society upon receipt of formal written charges filed by a licensed physician practicing or residing in the State of Illinois alleging violations of any of the offenses enumerated in this Part 3. Written charges received by the Illinois State Medical Society shall be referred to the Secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

PART 5. PENALTIES

The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership. A decision based on a recommendation to acquit shall be final and not appealable.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and all privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to his expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

PART 6. DECISION BY COMPONENT MEDICAL SOCIETY

- A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description if these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.
- B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

PART 7. JUDICIAL PANEL

A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an ini-

tial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs because of illness, death or resignation of a member or for any other reason, the President of the Illinois State Medical Society shall nominate a successor who shall serve by appointment of the Board of Trustees until the next meeting of the House of Delegates. At the meeting of the House of Delegates next occurring after the interim appointment has been made, the nominee then temporarily serving to fill the vacancy may be elected by the House of Delegates to an appropriate term, in accordance with provisions of these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees.

The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as is necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings*, to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

PART 8. DUE PROCESS SAFEGUARDS

In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW PART 1—DEFINITIONS

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient

relations issues. Medical Society peer review shall be conducted at the local level whenever possible. Ethical relations issues identified during deliberations of the Peer Review Committee shall be appropriately referred. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

PART 2—COMPONENT SOCIETY PROCEDURES

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component Society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review the decision of the component Society; except that a petition must set forth any one of the following grounds as a basis for the appeal:

1. **PROCEDURAL ERROR**—The peer review proceeding was not conducted in accordance with rules established by the component Society or the Illinois State Medical Society.
2. **BIAS**—The proceeding was conducted in a biased or arbitrary manner.
3. **INCOMPLETE INFORMATION**—If information not available to the component Society is submitted to the State Peer Review Appeals Committee, the Committee will first determine the relevancy of the new information. The case will be referred to the component Society for reconsideration if the infor-

mation is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

PART 3—DISTRICT COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

PART 4—ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the

Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review decisions of component or District Peer Review Committees accepted on appeal, in accordance with the provisions of Part 2 (D) of this Chapter. The state committee shall act to affirm, reverse, modify, or remand to the local or district committee such decision.

The state Committee shall have the authority to assign cases to District Peer Review Committees in accordance with Part 3 of this Chapter. Decisions of the State Committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1979-1980

Policy Manual

of the

Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its

next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request

Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion. (1973 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists. (1975 Annual Meeting)

Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

I. General

These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

II. Acceptable Professional Identification

1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours
6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforeseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority

of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.

12. Public announcement of changes in any of the above

III. Professionally Unacceptable

1. Testimonials or anecdotal reports of medical practice successes
2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

IV. Media Guidelines

1. Newspapers and magazines
 - a. Type size shall be that text type used in the publication
 - b. Use of any ornaments, embellishments, or symbols is prohibited
2. Professional or business cards, and office signs giving allowable information are permissible
3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above

(1979 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance

policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation. (1974 Annual Meeting)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as halfway houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged. (1974 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois. (1972 Annual Meeting)

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential. (Prior to 1965)

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned. (1968 Annual Meeting)

Autopsies, Declining Number of

Because the autopsy has educational benefits for medical science as well as the family of the deceased individual, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.

(1978 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods. (1971 Annual Meeting)

Blood Availability

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state. (1979 Annual Meeting)

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

(1971 Annual Meeting)

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

(Prior to 1965)

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through comprehensive health planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

(1978 Interim Meeting)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of the confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in total opposition to the use of the Social Security number as a universal number identifier. (1976 Interim Meeting)

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration. (1967 Annual Meeting)

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS should continue to support the efforts of county medical societies in becoming certified for sponsoring continuing medical education programs meeting the requirements promulgated by the Liaison Committee on Continuing Medical Education and the regulations of the State of Illinois.

Financial support for ICCME is provided by the Board of Trustees of ISMS, based upon the needs as determined by the ISMS Finance Committee, such needs to include provisions for contingencies. To each annual meeting of the House of Delegates an annual financial report, indicating (a) major sources of income and (b) major categories of expenditure for the year preceding, plus a copy of the budget adopted by the ICCME Board for the year in which the House is meeting, will be submitted.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. (1978 Interim Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous

availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage. (1978 Interim Meeting)

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult." (Prior to 1965)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians. (1977 Annual Meeting)

Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

- (a) The irreversible cessation of spontaneous respiratory and circulatory functions; or
- (b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

(1977 Annual Meeting)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based on what must necessarily be a private matter between physician and patient.

(1977 Annual Meeting)

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

(Prior to 1965)

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the

authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

(1976 Interim Meeting)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

(1976 Annual Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

(1966 Annual Meeting)

Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

(1973 Annual Meeting)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

(1976 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.

(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

(1976 Interim Meeting)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.

(1978 Annual Meeting)

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

(1973 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to ex-

plain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.

(1977 Interim Meeting)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

(1967 Annual Meeting)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

(1977 Interim Meeting)

Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for out-patient diagnostic tests.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

Implying to patients that physician's charges above insurance benefit allowances are excessive;

Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

Suggesting that physicians perform alternative surgical procedures;

Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(1977 Interim Meeting)

Health Screening by Paramedical Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

(1974 Annual Meeting)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

(1977 Annual Meeting)

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

(1977 Annual Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative

and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

(1978 Annual Meeting)

Hospital Records and Their Availability

Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.

Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness.

Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required, to insurance companies, governmental agencies, or other hospitals.

Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.

Where litigation is involved, a physician may be required to release medical records in the absence of a signed patient authorization. In those instances, a physician should ascertain that he is required to release the medical records and that the agent so requiring the release has the appropriate authority.

(1976 Interim Meeting)

Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

(1973 Annual Meeting)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, especially to all children, or to encourage the local public health agency to perform

this function.

Every school district should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

(1976 Interim Meeting)

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

(Prior to 1965)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

(Prior to 1965)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

(1976 Annual Meeting)

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

(Prior to 1965)

Medical Diagnosis and Treatment

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis.

(1975 Annual Meeting)

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

(1972 Annual Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

(1971 Annual Meeting)

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

(1974 Annual Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

(1977 Annual Meeting)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

(1970 Annual Meeting)

Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

In addition, the Department of Mental Health and Developmental Disabilities should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically

seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches, and a physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

(1977 Annual Meeting)

Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgement shall prevail as to whether or not the parents should be notified of such treatment.

(1973 Annual Meeting)

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

(1972 Annual Meeting)

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

(1970 Annual Meeting)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

(1973 Annual Meeting)

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the

Nutrition Committee and the Council on Environmental and Community Health in 1971.
(1971 Annual Meeting)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.
(Prior to 1965)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting)

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.
(1968 Annual Meeting)

Peer Review

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical society peer review shall be conducted at the local level whenever possible. Major ethical relations questions identified during deliberations of the Peer Review Committee shall be appropriately referred.
(1978 Interim Meeting)

Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.
(1973 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take whatever action is necessary to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(1978 Interim Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.
(1977 Annual Meeting)

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

ISMS is opposed to any legislation which mandates insurance benefits for medical care of psychiatric illness into an optional status.
(1976 Interim Meeting)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting)

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

An extensive program of education and rehabilitation should be conducted for the recipients of public aid.

Rehabilitation of all recipients should be of paramount concern.
(1978 Interim Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contri-

Contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.
(1973 Annual Meeting)

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.
(Prior to 1965)

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965)

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco-smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.
(1979 Annual Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.
(1979 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting)

Third Party Intrusion Into Medical Judgment

Medical judgement and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.
(1978 Annual Meeting)

Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.
(1979 Annual Meeting)

Utilization Review

ISMS encourages hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment.

ISMS urges all third party payors—private insurance carriers as well as government—to provide reimbursement to hospitals and physicians for time and expense incurred in focused utilization review.
(1978 Interim Meeting)

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.
(Prior to 1965)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

(1971 Annual Meeting)

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

(1967 Annual Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

(1967 Annual Meeting)

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other approved purposes.

(Prior to 1965)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.

(1978 Interim Meeting)

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

(Prior to 1965)

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association,

this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

(1972 Annual Meeting)

Dues and Assessments, Distribution of Information Regarding

Proposed actions involving changes in dues and levying of assessments of the Illinois State Medical Society shall be distributed to delegates and county medical societies at least thirty (30) days prior to their consideration so that delegates can reflect with their constituents before representing them at meetings of the House of Delegates.

(1979 Annual Meeting)

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

(1967 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should almost without exception be elected from those having served first as alternate delegates.

(1976 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of pro-

viding the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.

(1978 Annual Meeting)

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

(1968 Annual Meeting)

IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings

It should be requested of authors or discussants that original papers presented before programs for which ISMS has primary fiscal sponsorship be submitted to the *Illinois Medical Journal* for publication consideration and the right of acceptance or refusal.

(1978 Interim Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.

(Prior to 1965)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(1977 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

(Prior to 1965)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.

(1976 Interim Meeting)

Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

(Prior to 1965)

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy
- establish new policy
- request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

(1967 Annual Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

(Prior to 1965)

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society

prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

(1971 Annual Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

(1974 Annual Meeting)

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees. (Prior to 1965)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.

(1978 Interim Meeting)

Medical Schools

The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

(1978 Annual Meeting)

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and

national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

(Prior to 1965)

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

(1970 Annual Meeting)

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

(Prior to 1965)

Policy Statements

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

(1967 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.

(1976 Interim Meeting)

Press

All county medical societies should be encouraged to cooperate with the local press. The public should be pro-

vided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.) (Prior to 1965)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for his liability coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange. (1975 Annual Meeting)

Public Statements

Only officially designated persons may publicly speak for the society. The Chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the Society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the Society's policies and positions. (1978 Annual Meeting)

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman. (Prior to 1965)

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected. (Prior to 1965)

Rebates

In conformity with the AMA Principles of Medical Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding

collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

(1968 Annual Meeting)

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience. (1967 Annual Meeting)

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved. (Prior to 1965)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Student Business Session shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis. (1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS. (1976 Interim Meeting)

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office. (Prior to 1965)

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval. (Prior to 1965)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians. (1974 Annual Meeting)

Policy Manual

APPENDIX

Multiphasic Health Testing Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition,

perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that

physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to

educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity,

specificity, high predictive value, and patient acceptance.

7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

Statement of Understanding

(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit

any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

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8th District—James Laidlaw
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203 N. Vine, Harrisburg 629461981
10th District—Julian W. Buser
6600 W. Main, Belleville 622231981
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52 Bunting Lane, Naperville 605401980
12th District—Joseph Perez
5670 E. State, Rockford 611081980
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826 E. 61st St., Chicago 606371980

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A complete listing of delegates and alternates to the ISMS House appears in the convention program.

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Newton DuPuy1968
Harlan English1964
David S. Fox1979
Edwin S. Hamilton1962
H. Close Hesseltine1961
J. M. Ingalls1976
Charles J. Jannings, III1972
Frank J. Jirka, Jr.1973
Fredric D. Lake1975
Willis I. Lewis1954
Burtis E. Montgomery1966
Edward A. Piszczek1965

Caesar Portes1967
Jacob E. Reisch (Honorary)1979
Willard C. Scrivner1974
Joseph H. Skom1977
Leo P. A. Sweeney1953
Philip G. Thomsen1969
George T. Wilkins, Jr.1978

Past Speakers

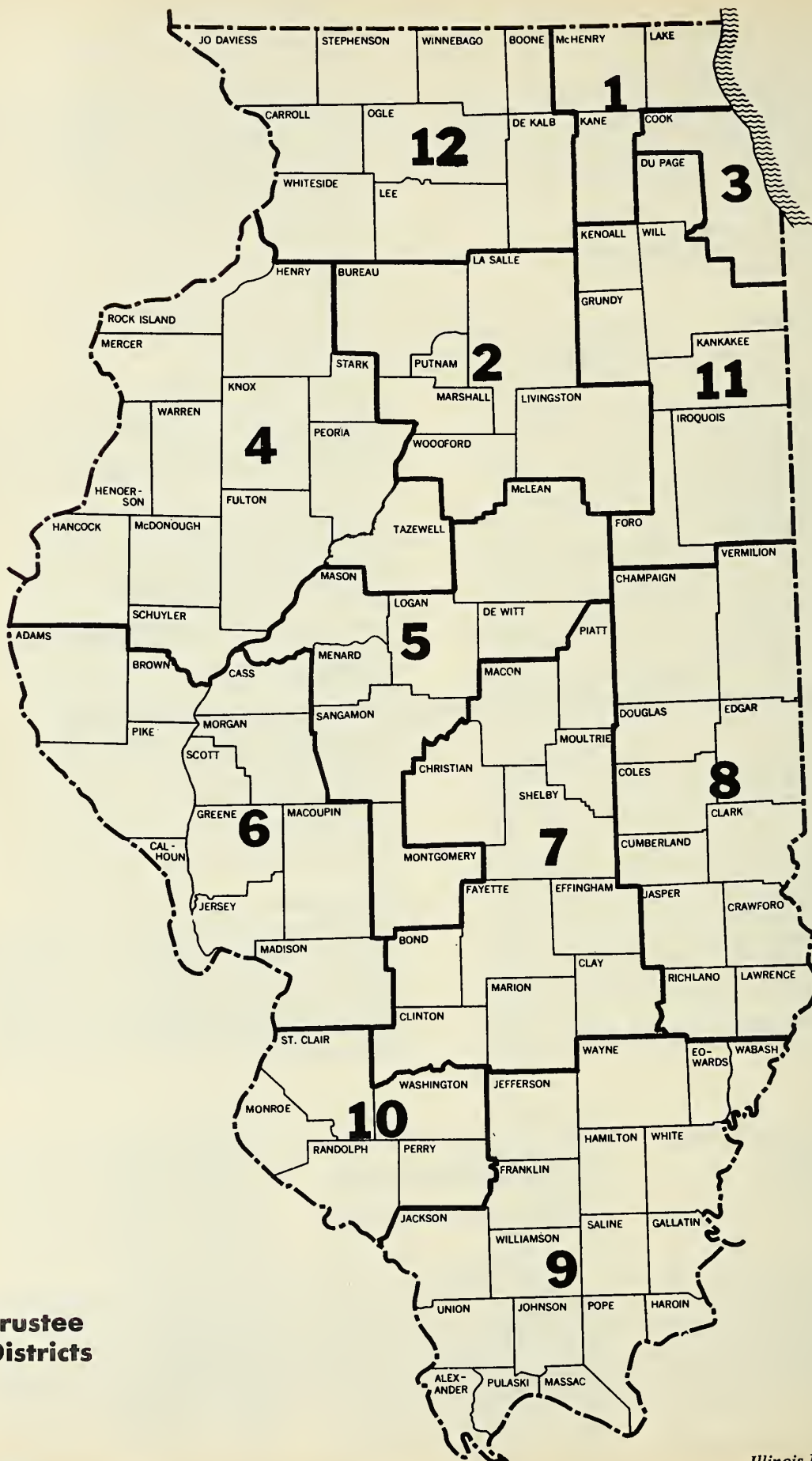
Walter C. Bornemeier, Chicago1961-1964
Andrew J. Brislen, Chicago1974-1975
Edward W. Cannady, Belleville1964-1967
Maurice M. Hoeltgen, Chicago1967-1970
James A. McDonald, Geneva1976-1977
Paul W. Sunderland, Gibson City1970-1973
Cyril C. Wiggishoff, Chicago1977-1979

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John J. Ring, Mundelein, *Trustee*
Counties of Kane, Lake, McHenry

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
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David Clark, Aurora, <i>Chairman</i>	1981
Emanuel Herzon, Elgin	1981
Gerald Liesen, St. Charles	1982
A. M. Rosetti, McHenry	1980

PEER REVIEW COMMITTEE	
David Helberg, Waukegan, <i>Chairman</i>	1981
Eugene Pitts, Waukegan	1981
James Pritchard, Geneva	1981
Peter Vinceguerra, Libertyville	1981

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
-----------------------------	-----------------

William Erkonen, Streator, <i>Chairman</i>	1980
Julius Kowalski, Princeton	1980
Karl T. Deterding, Pontiac	1980

PEER REVIEW COMMITTEE	
Louis Tarsinos, Princeton, <i>Chairman</i>	1982
James B. Aplington, LaSalle	1982
Silvio Davito, Spring Valley	1982
Bernard J. Doyle, LaSalle	1982
William Ehling, Streator	1980
Rowland Musick, Mendota	1982
Theodore Mauer, Chatsworth	1981
Theodore W. Wagenknecht, Streator	1982
Robert Betasso, Ottawa	1982

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Alfred Clementi, Arlington Heights, *Trustee*
Raymond DesRosiers, Chicago, *Trustee*
Jere Freidheim, Chicago, *Trustee*
Morris T. Friedell, Chicago, *Trustee*
Henrietta Herbolsheimer, Chicago, *Trustee*
Lawrence L. Hirsch, Chicago, *Trustee*
Harold J. Lasky, Chicago, *Trustee*
Richard N. Rovner, Chicago, *Trustee*
Joseph C. Sherrick, Chicago, *Trustee*
Cyril C. Wiggishoff, Chicago, *Trustee*

Fourth District

George Burke, Rock Island, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
-----------------------------	-----------------

Richard Icenogle, Roseville, <i>Chairman</i>	1980
Earl Clark, Rock Island	1981
Jerry Ramunis, Victoria	1982

PEER REVIEW COMMITTEE	
Donald Dexter, Macomb, <i>Chairman</i>	1980
William Daugherty, Moline	1981
G. W. Giebelhausen, Peoria	1981
James C. Parsons, Geneseo	1982
Clarence Ward, Peoria	1981
Richard Flacco, Galesburg	1982

Fifth District

Robert Prentice, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
-----------------------------	-----------------

Richard H. Suhs, Springfield, <i>Chairman</i>	1980
Jack Means, Mason City	1981
A. L. Van Ness, Bloomington	1982

PEER REVIEW COMMITTEE	
James Borgerson, Mt. Pulaski, <i>Chairman</i>	1980
Robert Price, Bloomington, <i>Co-Chairman</i>	1980
George Irwin, Bloomington	1982
Paul Lafata, Springfield	1980
Robert B. Perry, Lincoln	1982
Donald Yurdin, Springfield	1982
Clifford Draper, Hillsboro	1982

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
-----------------------------	-----------------

Newton DuPuy, Quincy, <i>Chairman</i>	1980
Bernard Baalman, Hardin	1981
Edward K. DuVivier, Alton	1980
Joseph J. Grandone, Gillespie	1980
C. B. Lara, Pittsfield	1981
Robert Roy, Jacksonville	1981

PEER REVIEW COMMITTEE	
Walter Stevenson III, Quincy, <i>Chairman</i>	1980
E. C. Bone, Jacksonville	1982
Robert England, Carlinville	1981
Robert C. Murphy, Quincy	1982
Edward Ragsdale, Alton	1980
James Sutherland, Quincy	1980
Robert F. Hamilton, Alton	1981

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham,
Fayette, Macon, Marion, Moultrie, Piatt, Shelby

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. Gale Zacheis, Decatur, <i>Chairman</i>	1982
C. R. Daisy, Greenville	1981
E. F. Stephens, III, Centralia	1982
I. Del Valle, Taylorville	1982

PEER REVIEW COMMITTEE	
M. K. Kaufman, Greenville, <i>Chairman</i>	1980
H. Gale Zacheis, Decatur	1980
Clarence G. Glenn, Decatur	1982
D. H. Rames, Vandalia	1982

Eighth District

James Laidlaw, Champaign, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cum-
berland, Douglas, Edgar, Jasper, Lawrence, Richland,
Vermilion

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Mack W. Hollowell, Charleston, <i>Chairman</i>	1980
James H. Pass, Olney	1981
R. R. Manson, Urbana	1982

PEER REVIEW COMMITTEE	
Michael Murray, Olney, <i>Chairman</i>	1982
E. T. Baumgart, Danville	1980
George T. Mitchell, Marshall	1981
C. E. Ramsey, Charleston	1982
Gordon Sprague, Paris	1982
R. C. Adams, Champaign	1982

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin,
Hamilton, Hardin, Jackson, Jefferson, Johnson, Mas-
sac, Pope, Pulaski, Saline, Union, Wabash, Wayne,
White, Williamson.

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Alex Goldstein, Harrisburg, <i>Chairman</i>	1982
Eli Borkon, Carbondale	1980
Robert Rader, Anna	1980

PEER REVIEW COMMITTEE	
C. J. Jannings, III, Fairfield, <i>Chairman</i>	1982
Philip D. Boren, Carmi	1980
Herbert V. Fine, Cartersville	1981
James Heersma, Mt. Vernon	1982
Harry L. Lewis, Benton	1981
Charles K. Wells, Mt. Vernon	1982

Tenth District

Julian W. Buser, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Wash-
ington

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. P. Dexheimer, Belleville, <i>Chairman</i>	1982
Roy Kenney, E. St. Louis	1982
Edilberto Maglasang, Columbia	1982
Wm. A. Simmons, Belleville	1982

PEER REVIEW COMMITTEE	
William H. Walton, Belleville, <i>Chairman</i>	1981
Benjamin Arenas, Belleville	1982
Ted Bryan, Belleville	1982
R. W. Jost, Waterloo	1981
R. E. Schettler, Red Bud	1980
Ron Welch, Belleville	1981

Eleventh District

Kenneth Hurst, Naperville, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,
Kendall, Will

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
James Ryan, Kankakee, <i>Chairman</i>	1981
Lawrence D. Lee, Manhattan	1982
Merle Otto, Frankfurt	1982
William C. Perkins, West Chicago	1982

PEER REVIEW COMMITTEE	
James Campbell, Wheaton, <i>Chairman</i>	1981
James E. Dailey, Watseka	1981
Guy Pandola, Joliet	1981
A. G. Parkhurst, Kankakee	1980
W. H. Brill, Oswego	1980
Charles G. White, Naperville	1982
Alex Spadoni, Joliet	1982

Twelfth District

Joseph Perez, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee,
Ogle, Stephenson, Whiteside, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
John H. Steinkamp, Belvidere, <i>Chairman</i>	1981
Keith Wrage, Rockford	1980
Frank Luedke, DeKalb	1981
Frank Descourouez, Freeport	1982

PEER REVIEW COMMITTEE	
Keith Wrage, Rockford, <i>Chairman</i>	1980
Frank Luedke, DeKalb	1981
John H. Steinkamp, Belvidere	1981
Frank Descourouez, Freeport	1982

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON AFFILIATE SOCIETIES

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 Ill. Section, American College of OB-GYN
 Jerome S. Beigler, Chicago
 Ill. Psychiatric Society
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 Chicago Laryngological and Otolological Society
 Robert Dodd, Springfield
 Ill. Society of Anesthesiologists
 Charles Downing, Decatur
 Ill. Chapter, American College of Physicians
 Richard E. Dukes, Urbana
 Ill. Chapter, American Academy of Pediatrics
 Malachi Flanagan, Chicago
 Chicago Urological Society
 Carl Garfinkle, Arlington Heights
 Ill. Association of Ophthalmology, Inc.
 Donald H. Hanscom, Hinsdale
 Ill. Society of Internal Medicine
 B. Jay Hill, Chicago
 Ill. Radiological Society
 Donald R. Ingram, Godfrey
 Ill. Society of Ophthalmology and Otolaryngology
 Martin J. Kaplan, Highland Park
 Allergy and Clinical Immunology Society of Ill.
 M. Barry Kirschenbaum, Chicago
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James F. Kurtz, LaGrange
 Ill. Orthopaedic Society
 Ronald P. Pawl, Chicago
 Ill. Neurosurgical Society
 J. Roger Powell, Urbana
 Ill. OB-GYN Society
 Alan B. Spacone, Glen Ellyn
 Ill. Chapter, American College of Emergency Physicians
 Robert Swastek, Chicago
 Ill. Chapter, American Academy of Family Physicians

OTHER ORGANIZATIONS REPRESENTED:

Illinois Society of Pathology
 Illinois Surgical Society

CONSULTANTS:

Jere Freidheim, Chicago
 Harold Lasky, Chicago
 Cyril Wiggishoff, Chicago

STAFF: Division for Specialty Societies

Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS

Alex Spadoni, Joliet, *Chairman*
 E. Boone Brackett, Oak Park
 Jess Diamond, Springfield
 Jesse Frederick, Rockford
 Theodore Grevas, Rock Island
 William A. Hutchison, Chicago
 Robert E. Knight, Normal
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 Franz S. Steinitz, Chicago
 Fred A. Tworoger, Chicago
 Ronald G. Welch, Belleville

CONSULTANTS:

Raymond DesRosiers, Chicago
 Allan L. Goslin, Streator

STUDENT

Terry Hanusa, Oak Park

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Council on Economics maintains ongoing dialogue with third party payors and considers issues regarding the costs and utilization of health care services. The council is interested in effective practice management and the economic impact of both government health policies and new health care delivery systems.

COUNCIL ON EDUCATION AND MANPOWER

Donald Pochly, North Chicago, *Chairman*

David Bristow, Effingham

Milda Budrys, Chicago

Allison Burdick, Jr., Chicago

Donald Coder, Lake Forest

John Dietrich, Springfield

Joseph P. McKay, Elmhurst

Pedro Poma, Chicago

David Roxe, Chicago

Robert Tucker, MacKinaw

John Walter, Joliet

Simon Zivin, Chicago

RESIDENT

Scott B. Karl, Urbana

STUDENT

Lee Morisey, Chicago

CONSULTANTS:

Lawrence L. Hirsch, Chicago

Fred Z. White, Chillicothe

Robert P. Johnson, Springfield

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:

Physician Recruitment

Physician Recruitment—Urban

Committee to Coordinate Local SBS/RPS Activities

COMMITTEE ON PHYSICIAN RECRUITMENT

David Bristow, Effingham, *Chairman*

Bernard M. Baalman, Hardin

J. M. Ingalls, Paris

Ronald Ferguson, Chicago

Albert Maurer, Hopedale

Responsibilities and Purposes:

The Committee on Physician Recruitment is a permanent subcommittee of the Council on Education and

Manpower and is charged with coordinating physician recruitment activities in the state. An important responsibility of this committee is establishing contact with existing organizations that are concerned about physician-short areas of the state. In cooperation with other organizations, the committee should identify areas of physician shortage and develop mechanisms for these areas to recruit and retain physicians. In order to expedite its activities, the committee is authorized to divide itself into two sub-committees, one rural and one urban.

SUBCOMMITTEE ON PHYSICIAN RECRUITMENT—URBAN

David Roxe, Chicago, *Chairman*

Charles R. Frazer, East St. Louis

Earl Fredrick, Olympia Fields

RESIDENT

Thomas Carswell, Peoria

COMMITTEE TO COORDINATE LOCAL STUDENT BUSINESS SESSION (SBS) AND RESIDENT PHYSICIAN SECTION (RPS) ACTIVITIES

John Dietrich, Springfield, *Chairman*

James W. Bauer, Peoria

Daniel Bloomfield, Urbana

Craig Booher, Rockford

Ronald Johnson, Carbondale

James Reeder, Park Ridge

EX-OFFICIO MEMBERS

Benjamin LeCompte, III, Chicago (RPS)

David Aizuss, Chicago (SBS)

Responsibilities and Purposes:

This committee will coordinate activities of local components of the Student Business Session and Resident Physicians Section organized by county medical societies. The committee will be responsible for assisting in the activation of such groups in appropriate areas, providing guidance regarding student and resident input into component medical societies as well as into the ISMS/SBS and RPS.

GOVERNMENTAL AFFAIRS COUNCIL

Howard Burkhead, Evanston, *Chairman*

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J. Vickers Brown, Highland Park

James Cavanaugh, Jr., Winnetka

Edwin Falloon, Evergreen Park

Edward G. Ference, Springfield

William D. Fish, Chicago

Robert T. Fox, Glenview

Henri Havdala, Chicago

Don Hinderliter, Rochelle

Frank J. Kresca, Champaign

Paul Mahon, Springfield

Tassos Nassos, Northbrook

G. Samuel Stohl, Rockford

Michael Victor, D.O., Buffalo Grove

Walter Whisler, Chicago

CONSULTANTS:

George Burke, Rock Island

Audley Connor, Jr., Chicago

James Laidlaw, Champaign

Richard N. Rovner, Chicago

P. John Seward, Rockford

ILLINOIS MEDICAL GROUP MANAGEMENT

ASSN. REP.

Norma de la Cerna, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Alan Taylor, Danville

RESIDENT PHYSICIANS REPRESENTATIVE

Linda Hughey Holt, Chicago

STUDENT REPRESENTATIVE

Joan Balcombe, Chicago

STAFF: Governmental Affairs Division

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.

2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.

3. Co-operate with the AMA in similar programs.

4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Ad Hoc Eye Health

Public Affairs

AD HOC EYE HEALTH COMMITTEE

Frank J. Kresca, Champaign, *Chairman*

Charles Mullenix, Glenview

Burton Russman, Chicago

Frank Snell, Decatur

Robert W. Webb, East Alton

PUBLIC AFFAIRS COMMITTEE

Don E. Hinderliter, Rochelle, *Chairman*

James H. Andersen, Oak Brook

Mack W. Hollowell, Charleston

George T. Mitchell, Marshall

Sandra J. Olson, Chicago

Michael P. Phillips, Chicago

Edward Ragsdale, Godfrey

Willard C. Scrivner, Belleville

Ronald E. Sumner, Peoria

Mrs. Pam Taylor, Danville

AUXILIARY REPRESENTATIVE

Mrs. Norman Taylor

STAFF: Division of Field Services

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Donald Aaronson, Chicago, *Chairman*
Nelson Borelli, Wilmette
Arthur Fischer, Westchester
Leonard Klawfta, Joliet
Guy Matthew, Glen Ellyn
Morgan Meyer, Lombard
Michael Murphy, Belleville
Lawrence K. Richards, Urbana
Marshall Segal, Chicago
Sam Sugar, Evanston
J. Robert Thompson, Chicago (*Lab. Services*)

CONSULTANT:

Alfred Kiessel, Decatur

RESIDENT

Barry LeCompte, Chicago

STUDENT REPRESENTATIVE

John Divers, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

Committees:

Impartial Medical Testimony
Laboratory Services

COMMITTEE ON LABORATORY SERVICES

J. Robert Thompson, Oak Park, *Chairman*
Newell Braatelein, Moline
Robert Carrara, Geneva
Joseph O. Dean, Peoria
Hershal Fulcher, Springfield
Marshall Short, Chicago
Peter Soto, Belleville
Earl Suckow, Mt. Prospect
Oscar Wilbur, Rockford
Benjamin Williams, Urbana

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Arthur R. Traugott, Urbana, *Chairman*
Jerome Beigler, Chicago (*IPS Liaison*)
Douglas R. Bey, Normal
George Borge, LaGrange
Marvin Dehaan, Wayne
Thomas E. Kirts, DeKalb
Edward Senay, Chicago
(*Comm. on Alcoholism & Drug Dependence*)
Mark Sinabaldi, Joliet
Kishore Thampy, Chicago
James West, Evergreen Park
Arthur Woloshin, Highland Park

CONSULTANT:

David S. Fox, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Donald Rager

STUDENT REPRESENTATIVE

Debbie Gusnard, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information, and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

Committee:

Alcoholism and Drug Dependence
Ad Hoc Study Committee on Designated Products

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Edward C. Senay, Chicago, *Chairman*
 Lee Gladstone, Chicago
 Richard Lee, Peoria
 Kermit Mehlinger, Chicago
 Reinhold Schuller, Bourbonais
 W. David Steed, Oak Park
 David Stinson, Rockford

CONSULTANTS:

Linda Hargnett, DDC, Chicago
 Msgr. Ignatius McDermott, Chicago Catholic Charities
 J. Roalda Alderman, Div. of Alcoholism, Chicago
 Mrs. Harold Keegan, ISMS Auxiliary, Kankakee

STAFF: Division of Publications, Medical-Legal and
 Mental Health

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the mis-

use of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products; and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to mental or emotional disturbances.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Peter Vinciguerra, Libertyville, *Chairman*
 Albino Bismonte, Gurnee
 Mark Bullock, Peoria
 Bernie Cahill, Peoria
 Jack L. Gibbs, Canton
 Adarsh Kumar, Springfield
 Leo Wrona, Joliet

CONSULTANT:

Herschel Browns, Chicago

STUDENT REPRESENTATIVE:

Michael Nieder, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Don Hinderliter, Rochelle

STAFF: Division of Public Relations and
 Membership Services

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

Committees:

Sports Medicine

SPORTS MEDICINE COMMITTEE

Bernie Cahill, Peoria, *Chairman*
 Robert Hamilton, Chicago
 Joseph Hinkamp, Glenview
 J. M. Ingalls, Paris
 H. Bates Noble, Chicago
 Basilius Zaricznyj, Springfield

CONSULTANT:

Audley Connor, Jr., Chicago

STAFF: Division of Public Relations and Membership
 Services

Responsibilities and Purposes:

To conduct programs aimed at improving the recognition and treatment of athletics-related injury and disease; provide educational material to junior and senior high school coaches and trainers; and work with other groups and organizations involved in sports medicine activities.

COUNCIL ON MEDICAL SERVICES

Shirley A. Roy, Chicago, *Chairman*
Joan Cummings, Hines
William W. Curtis, Springfield
Theodore Dastych, Joliet
A. Everett Joslyn, River Forest
Max Klinghoffer, Elmhurst
William M. Lees, Lincolnwood
David B. Littman, Highland Park
John T. McEnery, Oak Park
Roger N. Pesch, Wheaton
Eugene J. Rogers, Chicago
Joseph D. Winterhalter, Jacksonville

CONSULTANTS:

Vincent A. Costanzo, Jr., Chicago
John J. Ring, Mundelein

AUXILIARY REPRESENTATIVE

Mrs. Harold Keegan, Kankakee

RESIDENT REPRESENTATIVE:

Lawrence V. Gratkins, Evanston

STUDENT REPRESENTATIVE

Ronald M. Davis, Chicago

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Council considers a broad range of public health issues and implements programs related to medical facilities, professional health education, and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workmen's compensation, and the penal health care services.

Committees:

Maternal Welfare
Committee on Workmen's Compensation
Illinois Jail Health Program—State Technical Advisory Committee

COMMITTEE ON MATERNAL WELFARE

DISTRICT MEMBERS AND ALTERNATES

(*alternates in italics*)

William W. Curtis, Springfield, *Chairman*

1. Hugh C. Falls, Lake Forest
Theodore London, Aurora
2. Carl P. Mattioda, Streator
Ruthachai Rithaporn, Princeton
3. Warren H. Staley, Chicago
Robert C. Stepto, Chicago
4. Raoul E. Reinertsen, Canton
Charles C. Egley, Peoria
5. William W. Curtis, Springfield
William H. Schultz, Springfield
6. Richard D. Yoder, Alton
Donald E. Hardbeck, Alton
7. Herbert W. Thompson, Decatur
William L. Wagner, Decatur
8. John C. Mason, Jr., Danville
Lewis Trupin, Champaign
9. Urduja Pulido, Murphysboro
Roger N. Klam, Carbondale

10. Arthur A. Smith, O'Fallon

Stephen V. Mueller, Belleville

11. Salvatore Reda, Wheaton

Kenneth M. Uznanski, Joliet

12. John F. Hubbard, Sterling

Gordon T. Burns, Rockford

CONSULTANTS:

Robert R. Hartman, Jacksonville
John Lewis, Lake Forest
Augusta Webster, Chicago

STAFF: Division of Medical Services

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

COMMITTEE ON WORKMEN'S COMPENSATION

Eugene J. Rogers, Chicago, *Chairman*

Harry C. Coblens, Chicago

Donald J. Crane, Peoria

Vincent Sarley, North Chicago

Joseph Schiff, Chicago

STAFF: Division of Medical Services

Responsibilities and Purposes:

To review how physicians are involved and affected by the Workmen's Compensation system in Illinois.

STATE TECHNICAL ADVISORY COMMITTEE ILLINOIS JAIL HEALTH PROGRAM, 1979-1980

Robert J. Kramer, Joliet, *Chairman*

Margaret Connolly, Illinois Nurses Association

Hon. Thomas P. Durkin, Ill. State Bar Association

Cyril L. Friend, Jr., DDS, Ill. State Dental Society

Marie Hall, Ill. Department of Corrections

Courtney Jones, Chicago

Barbara Lewis, Assoc. of Administration of Ambulatory Services

David B. Littman, Highland Park

Mary Lou Pflum, Div. of Ambulatory Care, IDPH

Tony Slas, Ill. Pharmaceutical Association

Joseph D. Winterhalter, Jacksonville

STAFF: Division of Medical Services

Responsibilities and Purposes:

To provide overall direction to the Illinois Jail Health Program and assist jails in adapting their health systems to meet national standards for medical care delivery. The STAC is an independent body which reports to the Council on Medical Services.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

David S. Fox, Chicago, *Chairman*
Robert R. Hartman, Jacksonville
P. John Seward, Rockford
STAFF: Division of Administration

Responsibilities and Purposes:

The committee shall consist of the immediate past

president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

COMMITTEE ON COMMITTEES

Henrietta Herbolzheimer, Chicago, *Chairman*
Julian Buser, Belleville
Warren D. Tuttle, Harrisburg

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It

shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS

Cyril C. Wiggishoff, Chicago, *Chairman*
David S. Fox, Chicago
James Laidlaw, Champaign
Joseph Perez, Rockford
John J. Ring, Mundelein

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

EXECUTIVE COMMITTEE

Robert R. Hartman, Jacksonville, *Chairman*
David S. Fox, Chicago
P. John Seward, Rockford
Herschel Browns, Chicago
Audley Connor, Chicago
Morris T. Friedell, Chicago
Alfred J. Kiessel, Decatur
Fred Z. White, Chillicothe

BY INVITATION (without vote)

Robert P. Johnson, Springfield

STAFF: Division of Administration

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the

Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Alfred J. Kiessel, Decatur, *Chairman*
Alfred Clementi, Arlington Heights
Audley F. Connor, Jr., Chicago
Joseph Perez, Rockford

AUXILIARY REPRESENTATIVES

Mrs. A. Martinucci
Mrs. R. Reardon

STAFF: Division of Administration

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the

Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

POLICY COMMITTEE

Morris T. Friedell, Chicago, *Chairman*
Lawrence L. Hirsch, Chicago
George Burke, Rock Island

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

PUBLICATIONS COMMITTEE

Kenneth A. Hurst, Naperville, *Chairman*
Robert P. Johnson, Springfield
Harold J. Lasky, Chicago
B. Franklin Lounsbury, River Forest
Joseph Sherrick, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to accept-

ance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Daniel R. Cunningham, Wilmette
Raymond A. Dieter, Jr., Glen Ellyn
James G. Ekeberg, Palatine
Ediz Z. Ezdinli, Kenilworth
Carl Neuhoff, Peoria
Constantine S. Soter, Northbrook
Donald D. VanFossan, Springfield

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Fred Z. White, Chillicothe, *Chairman*
Herschel Browns, Chicago
Raymond DesRosiers, Chicago
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Robert L. Prentice, Springfield
Clifton L. Reeder, Park Ridge
Richard N. Rovner, Chicago

ILL. MEDICAL GROUP MNGMT. ASSOC. REP.
Ms. Nancy Mauck, Chicago

STAFF: Division of Field Services

Responsibilities and Purposes:

The Third Party Payment Processes Committee is responsible for matters concerning the Illinois Department of Public Aid. The Committee deals with Medicaid reimbursement, administration, and auditing practices. The Committee also oversees the Medicaid Membership Services program.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Dean R. Bordeaux, M.D., Peoria, *Chairman*
Philip D. Anderson, Chicago
Robert A. Behmer, Rockford
James H. Geist, Kankakee
Julius S. Newman, Aurora
Maynard I. Shapiro, Chicago
D. Dax Taylor, Springfield

CONSULTANTS:

Audley F. Connor, Chicago
Lawrence L. Hirsch, Chicago
Warren D. Tuttle, Harrisburg

STAFF: Illinois Council on Continuing Medical Education

Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review Sponsor applications and Survey Team reports for intrastate CME Sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Charles A. Beck, Chicago
William Hanigan, Peoria
John Hyde, Oak Park
Arthur R. Marks, Fairfield
Joseph Skom, Chicago

CONSULTANTS:

Louis Gdalan, R.Ph., Oak Brook
Kerrison Juniper, Jr., Springfield

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

HEALTH DATA COMMITTEE

Allan Goslin, Streator, *Chairman*
Andrew Brislen, Chicago
Audley F. Connor, Chicago
Alexander Goldstein, Harrisburg
Donald H. Hanscom, Hinsdale
Henrietta Herbolzheimer, Chicago
James Laidlaw, Champaign
Joseph R. O'Donnell, Glen Ellyn
Paul Peterson, Chicago
Clifton L. Reeder, Chicago
Walter Stevenson, Quincy
Ben T. Williams, Urbana

CONSULTANT:

Roger N. White, Executive Administrator

STAFF: Division of Field Services

Responsibilities and Purposes:

The committee shall maintain ongoing awareness of:
(1) systems for the collection and dissemination of

health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.

COMMITTEE ON HEALTH PLANNING

B. Smith Hopkins, Urbana, *Chairman*
Ronald F. Albrecht, Chicago
Samuel L. Andelman, Skokie
Eli L. Borkon, Carbondale
Robert A. Clark, D.O., Chicago
Robert D. Dooley, Oak Brook
Melvin J. Freedman, Granite City
Gerald W. Grawey, Peoria
M. Kenneth Kaufmann, Greenville
Richard S. Webb, Rockford

CONSULTANT:

Henrietta Herbolzheimer, Chicago

STAFF: Division of Field Services

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

COMMITTEE ON INSURANCE

William A. Henry, Springfield, *Chairman*
Phillip Boren, Carmi
Charles F. Eddingfield, Carthage
Herbert H. Epstein, Glencoe
B. Franklin Lounsbury, Chicago
Gerald S. Modjeska, Chicago
Francisco Yanez-Seijo, Chicago

CONSULTANT:

Warren D. Tuttle, Harrisburg

STAFF: Division of Medical Services

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. The committee critiques current policies and investigates other insurance programs in order to recommend changes that may benefit society members.

PEER REVIEW APPEALS COMMITTEE

Michael E. Murray, Olney, *Chairman*
Boonmee Chunpraphaph, Hinsdale
Eugene T. Hoban, Oak Park
Carl Johnson, Moline
Courtland L. Munroe, Carbondale
Lloyd E. Thompson, East St. Louis
James H. Topp, Rockford

STAFF: Division of Medical Services

Responsibilities and Purposes:

This committee serves as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee serves as liaison to local peer review committees and monitors activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Herschel Browns, Chicago, *Chairman*
Robert Becker, Joliet
Howard Fishman, Hines
David S. Fox, Chicago
Mack W. Hollowell, Charleston
J. M. Ingalls, Paris
Charles Jannings, Fairfield
Eugene P. Johnson, Casey
Joseph B. Perez, Rockford
Clifton L. Reeder, Park Ridge
John J. Ring, Mundelein
Harry A. Springer, Winnetka
Michael R. Treister, Chicago

Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Edwardsville

STAFF: Division of Administration

Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON COST EFFECTIVENESS

David S. Fox, M.D., Chicago (ISMS) *Chairman*
 Mr. Stephen Dorn, Chicago (Chgo. Hosp. Coun.)
 Mr. Martin Drebin, Evanston (Ill. Hosp. Assoc.)
 Robert T. Fox, M.D., Glenview (ISMS)
 Morris T. Friedell, M.D., Chicago (Chgo. Med. Soc.)
 Mr. Charles Goulet, Chicago (BC-BS)
 Robert R. Hartman, M.D., Jacksonville (ISMS)
 Duane Heintz, Moline (Deere & Co.)
 J. M. Ingalls, M.D., Paris (ISMS)
 Robert Ivancevich, Oak Brook (Ill. Hosp. Assoc.)
 Mr. F. Regis Kenna, Addison (Ill. Hosp. Assoc.)
 Mr. Robert Lindley, Chicago (Chgo. Med. Soc.)
 Mr. James Mortimer, Chicago (Loop Bank Task Force on Health)

Mr. Gerald Mungerson, Chicago (Ill. Hosp. Assoc.)
 Mr. Robert O'Leary, Oak Brook (Ill. Hosp. Assoc.)
 Clifton L. Reeder, M.D., Park Ridge (Chgo. Med. Soc.)
 Mr. Philip J. Sayles, Woodstock (Ill. Clinic Mgrs. Assoc.)
 Fred Schwartz, Chicago (Chgo. Med. Soc.)
 Mr. Frank Schwermin, Highland Park, (Chgo. Hosp. Coun.)
 Mr. Steve L. Seiler, Lake Forest (Ill. Hosp. Assoc.)
 P. John Seward, M.D., Rockford (ISMS)
 C. Jon Shattuck, Chicago (BC/BS)
 Richard C. Shaw, M.D., Chicago (BC-BS)
 Mr. James R. Slawny, Chicago (ISMS)
 Mr. Roger N. White, Chicago (ISMS)

TASK FORCE ON THE MENTAL HEALTH CODE

David S. Fox, Chicago, *Chairman*
 Jerome S. Beigler, Chicago
 James L. Cavanaugh, Jr., Chicago
 Robert DeVito, Chicago
 Harvey M. Freed, Chicago
 Robert R. Hartman, Jacksonville
 S. Dale Loomis, Chicago
 Alex Spadoni, Joliet
 Patrick R. Staunton, Park Ridge
 Thomas T. Turlentes, Rock Island
 Arthur Traugott, Urbana
 Jane Ulsafer-VanLanen, RN, Chicago
 Sandra Nye, J.D., M.S.W., Oak Park

The ISMS-sponsored Task Force on the Mental Health Code was created to analyze the new Illinois Mental

Health Code and propose needed changes. Created in late 1978, the Task Force combines the expertise of ISMS, the Illinois Psychiatric Society, Illinois Department of Mental Health and Developmental Disabilities and Illinois Nurses Association.

The Task Force already has provided guidelines to assist Illinois physicians and private hospitals in complying with the new Code. The guidelines are intended to outline major provisions of the new law, answer some commonly-asked questions and offer suggestions for coping with difficult sections of the Code.

Several important amendments developed by the Task Force have been signed into law, and the Task Force will be working to formulate additional changes in the Code as the need arises.

TASK FORCE ON NEW HEALTH PRACTITIONERS

Pedro A. Poma, Chicago, *Chairman*
 Bernard Baalman, Hardin
 Howard Burkhead, Evanston
 Joan Cummings, Hines
 Marvin DeHaan, Wayne
 Melvin Freedman, Granite City
 John Froiland, Chicago
 Allan Goslin, Streator
 Henri Havdala, Chicago
 Boyd McCracken, Greenville
 Daniel Pachman, Chicago
 Richard Rovner, Chicago

Randolph Seed, Chicago
 Harold Zenisek, Rockford

CONSULTANTS:

Morris Friedell, Chicago
 Joseph Perez, Rockford

Responsibilities and Purposes:

The Task Force on New Health Practitioners shall be responsible for monitoring the activities of those health professionals sometimes known as "physician extenders," whose activities tend to duplicate or encroach upon the prerogatives and responsibilities of physicians licensed to practice medicine in all its branches. The task force shall make its recommendations to the Board of Trustees.

TASK FORCE ON PROFESSIONAL LIABILITY

Walter Whisler, Chicago, *Chairman*
 Ill. State Medical Society/Ill.
 Neurological Society
 George Andrews, Ottawa
 Ill. Assoc. Osteopathic Physicians
 Thomas Baffes, Park Ridge
 Chgo. Surgical Society
 Jerome S. Beigler, Chicago
 Ill. Psychiatric Society
 Leonard Berlin, Wilmette
 Chgo. Radiological Soc.
 Marshall L. Blankenship, Homewood
 Ill. Dermatological Society
 Phillip D. Boren, Carmi
 Ill. State Medical Society
 Joseph Caminiti, Oak Brook
 Ill. Hosp. Assoc.
 Clinton L. Compere, Chicago
 Ill. Orthopaedic Society
 David L. Doud, Normal
 Amer. College of Surgeons
 Charles F. Downing, Decatur
 Ill. Chap., Amer. College of Phys./
 Ill. Society of Internal Med.
 Thomas P. Driscoll, Chicago
 Ill. Chap.,
 Amer. Academy of Pediatrics
 David S. Fox, Chicago
 Ill. State Medical Society
 Morris T. Friedell, Chicago
 Ill. State Medical Society
 John P. Harrod, Jr., Chicago
 Amer. Coll. OB-GYN, Ill. Sec.
 Henri Havdala, Chicago
 Ill. Soc. of Anesthesiologists
 Alex Jablonowski, Elgin
 Ill. Chap.
 Amer. Col. of Emergency Phys.
 Kenneth Jesunas, Joliet
 Ill. Soc. of Ophth. &
 Otolaryngology
 Robert P. Johnson, Springfield
 Ill. State Medical Society

Alfred J. Kiessel, Decatur
 Ill. State Medical Society
 Harold Kirk, Oak Park
 Ill. Assoc. of Ophthalmology
 Benjamin LeCompte III, Chicago
 Chicago Medical Society
 James H. Mason, Evanston
 Ill. Surgical Society
 Guy Matthew, Chicago
 Ill. Radiological Society
 Peter McKinney, Chicago
 Chgo. Society of Plastic Surgery
 Tassos Nossos, Chicago
 Ill. State Medical Society
 Vincent J. O'Connor, Chicago
 Chgo. Urological Society
 Robert O'Leary, Oak Brook
 Ill. Hospital Association
 Clyde Phillips, Chicago
 Cook County Phys. Assoc.
 J. Roger Powell, Urbana
 Ill. OB-GYN Society
 Karl Richardson, Chicago
 Chgo. Dental Soc.
 Carlo Scuderi, Chicago
 Ill. Orthopaedic Society
 David Segal, Oak Brook
 Ill. Hospital Association
 Marshall Short, River Forest
 Ill. Society of Pathologists
 Irwin A. Smith, Northbrook
 Ill. Academy of Family Phys.
 Thomas Starshak, D.D.S., Aurora
 Ill. State Dental Society
 Thomas Szwed, Chicago
 Ill. Assoc. Osteo. Phys. & Surgs.
 Richard S. Wilbur, Lake Forest
 Ill. State Medical Society
 Don Wood, Chicago
 Chgo. Hospital Council
 STAFF: Division of Publications,
 Medical-Legal and Mental
 Health

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

Frank B. Norbury, Jacksonville, *Chairman*
 Donald Aaronson, Niles
 Howard C. Burkhead, Evanston
 Eugene P. Johnson, Casey
 J. Robert Thompson, Oak Park

Responsibilities and Purposes:
 The Judicial Panel serves as an appellate, disciplinary

body. The 5-member panel, which is nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical practice. The panel accepts appeals after the case has been heard at the local level.

STAFF: Division of Medical Services

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*
Albert G. Bledig, Eldorado
Thomas Schrepfer, Havana

STAFF: Division of Education, Manpower and
Convention Services

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

INA-ISMS JOINT PRACTICE COMMITTEE

James E. Coeur, Carthage
Loren Boon, Danvers
Allan Goslin, Streator
Morris T. Friedell, Chicago

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and

nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Chicago
Alexander Goldstein, Harrisburg
Allan L. Goslin, Streator
Donald H. Hanscom, Hinsdale
Henrietta Herbolzheimer, Chicago
Joseph R. O'Donnell, Glen Ellyn

Clifton L. Reeder, Park Ridge
Walter Stevenson, Quincy
Roger N. White, *Executive Administrator*, ISMS
Ben T. Williams, Urbana
Vacancy

ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY
Robert R. Hartman, Jacksonville

LIAISON TO ILL. SOC. OF THE AMER. ASSOC.
OF MED. ASSTS.

PEDIATRIC COORDINATING COUNCIL
Daniel Pachman, Chicago

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE
Charles L. Swarts, Oak Park

ILLINOIS MEDICAL RECORDS ASSOC.
Clifton Reeder, Park Ridge

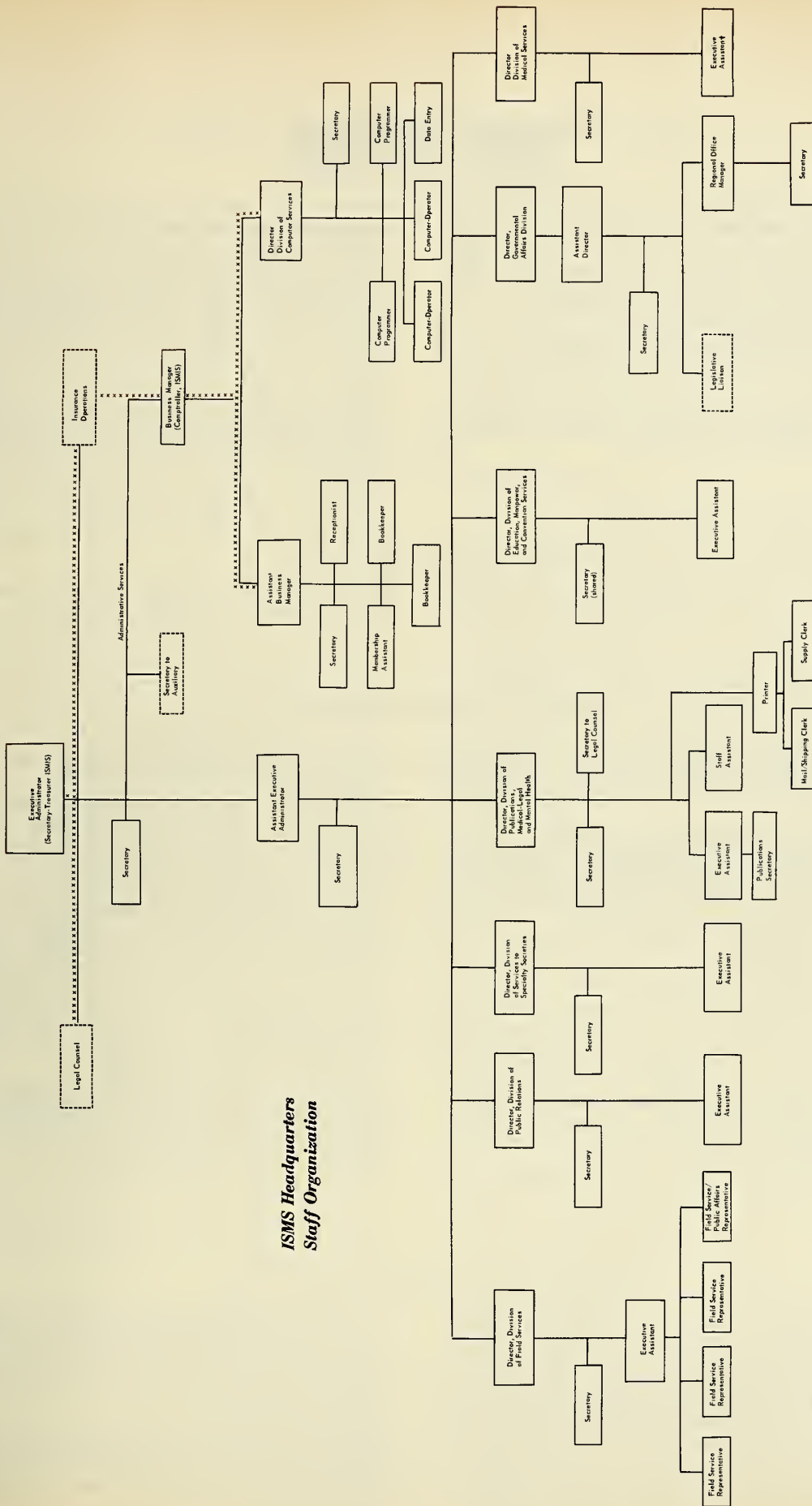
MD COMMITTEE ON OPTOMETRY
Samuel Schall, Chicago

STATEWIDE COOPERATING ORGANIZATIONS OF THE
COMMISSION ON CHILDREN
Daniel Pachman, Chicago

ILLINOIS CANCER COUNCIL
William M. Lees, Lincolnwood

CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM TO
CONTROL HIGH BLOOD PRESSURE
David Littman, Glencoe

U.S. PHARMACOPAEA
Joseph Skom, Chicago



ISMS Headquarters Staff Organization

Dashed lines denote part-time or
contracted personnel
*** Allocated services to ISMS

ISMS SERVICES

Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 701 S. Second St. Services of the Society, under the general supervision

of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; Medical Services, Field Services, Computer Services and Services to Specialty Societies.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by di-

visions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

The Division also supplies accounting, computer and legal services to Insurance Services, the Insurance Exchange and the Illinois Council on Continuing Medical Education, on a cost allocated basis.

DIVISION OF COMPUTER SERVICES

This Division was established in 1976 as a result of the Board of Trustees authorization to purchase a computer for the purpose of cataloging claim statistics in conjunction with the Hartford Liability Insurance program, sponsored by ISMS. Computer requirements were soon increased when the doctor-owned Insurance Exchange was established that same year. Insurance Services currently uses ISMS hardware and operations for its broad variety of business programs.

Computer services are provided internally to ISMS for

its centralized membership dues billing and collection system, financial record keeping and label production for the many Society mailings. A physician data base is currently being assembled as an information source for our councils and committees.

The Computer Service Division is being organized to provide limited time sharing arrangements and services to outside organizations. As we complete internal projects we shall seek further users in our effort to continue a cost effective system.

DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curricula, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and recommendations made to the ISMS Board of Trustees as

to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously. It is also responsible for coordinating meetings and conventions for all divisions, as well as the services and arrangements incident to the annual and interim sessions of the House of Delegates and provides staff services for the Resident Physicians Section, Student Business Session, and the American Association of Medical Assistants, Illinois Society.

DIVISION OF FIELD SERVICES

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine.

Specific areas of activity include health planning, President's Tour, Trustee District meetings, the legislative Key-Man program, public affairs activity, Medicaid and Medicare membership services, audit assistance, and

CHAMPUS professional relations.

Additional division activities include staffing the Third Party Payment Processes Committee, which deals with Medicaid matters; the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies; and the Public Affairs Committee, which conducts activities designed to educate physicians about the political process.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Activities

The division also staffs the Ad Hoc Eye Health Committee.

DIVISION OF MEDICAL SERVICES

To respond to the social and economic issues facing physicians, the Division of Medical Services conducts ongoing liaison activities with various public, governmental, professional, and private organizations. Through the Council on Economics and the Council on Medical Services, the Division reviews current subjects affecting the physician's practice environment, including his involvement with patients, medical facilities, public health programs, and health insurance carriers. The products of council meetings may take the form of educational seminars, informational materials, legislation, or position statements. In addition, Division staff monitors the development of new medical delivery systems to keep the Councils informed of potential changes affecting the practice milieu.

The Division is also responsible for staffing the ISMS Committee on Insurance, which monitors ISMS-sponsored insurance programs for the membership; the Judicial Panel, which conducts disciplinary procedures in accordance with Chapter XI of the ISMS Constitution and Bylaws; and the Peer Review Appeals Committee, which hears appeals of local peer review cases.

The Division has also been charged with implementation of the Illinois Jail Health Program, a project designed to improve the health care delivery systems of county jails. Staff responsibilities include providing technical assistance to jail sites and support to the program's State Technical Advisory Committee.

Council on Medical Services

The council studies issues and implements programs concerning the physician's role in health care facilities, the effective and appropriate delivery of medical services and the health care needs of specific population groups, such as children, the elderly, and the poor. Council activities also include maintaining liaison with the Illinois Department of Public Health and various health care organizations relating to areas such as hospital-medical staff relations, emergency medical services, nursing care, nutrition, school health, maternal welfare, and workmen's compensation.

Council on Economics

The principal duty of the Council on Economics is to

keep abreast of problems arising out of physicians' relationship with third-party payors. Additional areas of Council activity are the monitoring of government economic policies in the health care arena and assisting physicians with practice management problems. Serving as consultants to the Council are representatives from the Health Insurance Association of America and the Illinois Blue Cross/Blue Shield Association.

Committee on Insurance

ISMS offers seven insurance plans as benefits to the membership. Life, Hospital Benefit, Major Medical, Excess Major Medical, Disability, Business Overhead and Worker's Compensation programs are underwritten and administered through outside organizations. These are monitored and periodically modified by the Committee to reflect the changing needs of the membership.

Judicial Panel

Panel members are elected by the ISMS House of Delegates and charged with implementing Chapter XI, the disciplinary section of the ISMS Constitution and Bylaws. Meetings are held when ethical relations cases are appealed to the State Society following a hearing at the local or district level.

Peer Review Appeals Committee

This committee is responsible for hearing peer review cases on the appellate level, in accordance with Chapter XII of the Constitution and Bylaws. Cases concerning appropriate health care services and patient relations are heard by the Committee after they are considered by the local or district peer review committee.

State Technical Advisory Committee

This steering committee of the Illinois Jail Health Program includes members from the medical, nursing, legal, and correctional fields, with a particular interest in penal medicine. The committee reviews the status of health care delivery in county jails and recommends program objectives.

DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, Task Force on Professional Liability and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society. Staff functions include various activities in professional liability, as well as work on specific problem areas allied to medical-legal concerns and licensure.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are furnished either through an in-plant shop or outside services

through competitive bidding.

In addition, mail room services are provided by this division. A small wing mailer, folder and stuffer, and plate burning cabinet are utilized.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS and ISMS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

President's Tour . . . takes the ISMS President to each Trustee District and provides an opportunity for mem-

bers to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is press conferences and media interviews as well as civic club speaking engagements arranged by the division.

Action Report . . . is a periodic newsletter which reports on ISMS activities and major events affecting medicine.

AID (Athletics . . . Injury and Disease) . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

Public Service Announcements . . . providing general health information are distributed to approximately 150 Illinois radio stations and 28 TV stations.

DIVISION FOR SPECIALTY SOCIETIES

The Division for Specialty Societies was established in March, 1978 to provide closer liaison with medical specialty organizations in Illinois. The Division handles daily operations of several component groups, and provides staff services on a cost basis.

Services provided are divided into the following primary areas: (1) Routine office management, correspondence and inquiries; (2) Meeting arrangements; (3) Membership promotion and record keeping; (4) Dues collection and accounting services; and (5) Newsletters and other membership publications.

An important function of the Division is to maintain

liaison between ISMS and specialty society officers. The arrangement also permits close liaison with other ISMS divisions whose activities often affect specialty society interests, such as the Governmental Affairs Division and the Division of Publications, Medical-Legal and Mental Health.

The Division also staffs the Council on Affiliate Societies which is comprised of representatives from 21 Illinois specialty societies. The Council is responsible for providing specialty consultation to other ISMS councils and committees and serving as a resource unit to ISMS on advances in the medical specialties.

SPECIAL PUBLICATIONS

On the Legislative Scene

Emanating from the Springfield Regional Office is the newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in

Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

Action Report

"Action Report" is a periodic newsletter designed to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for

individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

In February, 1978, a special adjunct to the Scientific Speakers Bureau was formed through a grant from the

Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. That grant facilitates presentations by a special roster of speakers in alcoholism education.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Publicity to media in the area of the meeting will

be handled by ISMS upon request of the county society.

3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special ac-

tivities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is two-fold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will

contact the service.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the

student's current financial need. A low interest rate is charged from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organi-

zations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to ap-

proval by the program's board. The purpose of this agreement is to provide physicians for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; applicants must also complete the required American Medical College Admission Service forms. This AMCAS application must be on record with the University of Illinois Medical School by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is divergence of medical opinion in litigation before the court. An IMT examination provides the court with objective, impartial medical data and opinion.

The Illinois State Medical Society played a significant

role in the creation and development of the IMT program.

The panel of impartial medical examiners is comprised of physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission.

SPONSORED COMMERCIAL INSURANCE PROGRAMS

Hospital Benefit Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society will incur no expense as a result of sponsoring this voluntary program.

The Hospital Benefit Program consists of three plans. Plan A provides \$25 per day, Plan B provides \$50 per day and Plan C provides \$100 per day for each day you are confined in a hospital as an in-patient because of an accident or sickness for as long as one year. Benefits are provided from the first day of in-patient hospital confinement in any general hospital which has available 24-hour nursing services and has facilities for major surgery.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson Administrative Services, Inc., 209 S. LaSalle St.,

Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital, unless assigned. Benefits are not taxable and therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of

insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

Enrollment forms and details about the plan can be obtained by calling the Administrators Office, collect, at (312) 726-2575.

Group Disability Program

The Group Disability Program has been available to members since 1947. All eligible members of ISMS may apply if under age 55 and regularly attending all of the usual duties of their profession. The coverage is renewable to age 70 and offers three choices—Lifetime Accident and (1) Sickness payable to age 65, (2) Sickness payable for 7 years, (3) Sickness payable for 1 year.

New members under age 40 joining ISMS may enroll without evidence of insurability for up to \$400.00 per month. Benefits under Plan I include lifetime accident, 1 year sickness. The plan offers up to \$2166.00 per month benefits to members under 50 and \$1300.00 per month benefits to members under age 55.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60077.

Excess Major Medical Plan

This Plan has been available to members since 1975. It is a coverage designed for the truly catastrophic accident or illness condition. The plan provides up to \$500,000 for medical expenses. It is available with a \$15,000, \$20,000 or \$25,000 deductible which supplements any Basic Major Medical Plan. It may be obtained without evidence of insurability. You have 36 months to accumulate the deductible and then the benefits are paid on a 100% basis for up to 10 full years.

For additional information, please contact the Administrator, Parker, Aleshire & Company, 9933 Lawler Avenue, Skokie, Illinois 60077.

Workers' Compensation Insurance

The Dodson Savings Plan has been approved by the Illinois State Medical Society as a proven way to reduce the cost of Workers' Compensation insurance when claim costs are held to a minimum.

The savings for insured physicians were 20% the first year. Returns under this plan depend on the cost of claims from physicians who are insured. Policies are issued by Casualty Reciprocal Exchange, a member of the Dodson Insurance Group, and are standard in all respects. Rates are standard and approved for this class of employment. Savings are best when safety is maintained in all job related activities.

Savings are paid as earned within about 90 days after policy expiration or when payroll audits are completed.

For further details write or call collect to the managers, Dodson Insurance Group, P.O. Box 559, Kansas City, MO 64141. Phone 816-361-3400.

Group Major Medical Expense Plan

The \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has been in force since 1958. It has a 20% co-insurance feature with a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$150 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

Business Overhead Expense Group Plan

This plan has been available since 1973. Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for the physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$3,500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.B. 1955-19, p. 8).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

Personal Life Insurance Program

A non-cancellable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$300,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

Dividends are applied against premiums and reduce member's cost.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

Ancillary Organizations

Illinois State Medical Society Auxiliary

Focal Points—1979-1980

The Officers and Board of Directors of the Illinois State Medical Society Auxiliary have asked each member auxiliary to "focus on auxiliary" this year: to look at ourselves, as individuals and as a group—an inner perspective, and to direct our attention to our respective community's needs—a community perspective. Auxiliary members will be taking a sharp look at the medical profession's status in the community and what we can do to enhance the profession's public image—and, our primary focus, to endeavor to improve the quality of life through health education and services.

The Illinois Auxiliary has been enormously successful during the past year. Our AMAERF contribution was over \$30,000, the largest contribution ever. We must continue our efforts for this most worthwhile cause, as the costs of medical education continue their astronomical rise. The Auxiliary contribution to the Benevolence Fund was over \$10,000, also our largest contribution over the lifetime of the fund. Auxiliary members will plan fund raising projects for the benefit of Benevolence, and auxiliary members of the Benevolence Committee will continue to aid in the work of the committee.

Illinois was one of four states of the American Medical Association Auxiliary to show a continual gain in membership over four years. It is our goal to attract new members and maintain our existing numbers in order to show another gain for 1979-1980. To this end, county auxiliaries will invite spouses of physicians to special membership meetings this year. Programs should be evaluated in the light of membership desires and health projects implemented to present a positive public image of the Auxiliary.

At this point in time, medical legislation may be our most important priority. We must not only be aware of pending federal and state medical and social legislation, but we must act. The Auxiliary, through its legislation committee, and Key Woman program, will endeavor to promote positive legislation, answer LEGS alerts, and encourage political involvement of doctors and their families at the local level.

Promoting preventive medicine programs is nothing new for the Auxiliary. In the last few years, Illinois auxiliaries have promoted programs on immunization, CPR, nutrition, drug and alcohol abuse, water safety, automobile and bicycle safety, screenings for vision, hearing, blood pressure and scoliosis, to name but a few. Prevention will be our key focus this year.

Our Health Projects Team was inaugurated in October. Headed by the Health Projects chairmen, our team will design and explain preventive medicine/healthful lifestyle projects for Illinois county auxiliaries. Team members also are available to give programs upon request of the individual county auxiliary. The team has chosen the theme, "Follow the Yellow Brick Road to a

Healthy Mind and Body" for this year. Call them, they will come.

In order to implement the programs of the Auxiliary and to inform our members of the American Medical Association Auxiliary projects and priorities, a Fall Conference will be held in Bloomington on October 17. The program of this conference will feature the Health Projects Team and six workshops to inform and educate participants about current community health projects. Plans and ideas from the AMAA Convention and the AMAA Confluence will be discussed. All auxiliary members are invited and we hope that each of our organized counties will be represented.

Our officers, Board of Directors, and county leadership look forward to a challenging 1979-1980 year—a year to be one of cooperation and achievement as we "Focus on Auxiliary."

OFFICERS

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 President-Elect Mrs. Harlan Failor, Champaign
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 2nd Vice-President
 (Program) Mrs. Gamil Arida, Joliet
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 104 E. Broadway, Suite 5, Monmouth 61462

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 MembershipMrs. Donald Hinderliter, Rochelle
 ProgramMrs. Gamil Arida, Joliet
 Public

AffairsMrs. Norman Taylor, Rosewood Heights
 Spouses of Physicians in

TrainingMrs. Edward Szewczyk, Belleville

SPECIAL COMMITTEES

Senate Committee on

Child AbuseMrs. Earl Klaren, Libertyville
 Pseudo-Religious Cult

AwarenessMrs. George Olander, Lake Forest

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 Mrs. Robert Reardon, Bloomington
 Governmental AffairsMrs. Alan Taylor, Danville
 Mental Health and

AddictionMrs. Donald Rager, Peoria
 Public

AffairsMrs. Norman Taylor, Rosewood Heights
 Public Relations &

MembershipMrs. Don Hinderliter, Rochelle
 Medical ServicesMrs. Harold Keegan, Kankakee

American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Traveling Course Regional Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The Annual three day

meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this

program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 750 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (i.e. group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), Jefferson-Hamilton (Mt. Vernon), Kane (Elgin), LaSalle, Macon (Decatur), McLean (Bloomington), McHenry, Morgan-Scott (Jacksonville), Peoria, Randolph (Chester), Rock Island, Sangamon (Springfield), Shawnee (Harrisburg), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will-Grundy (Joliet) and Winnebago (Rockford). Physicians in these areas are asked to encourage their medical as-

sistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Cissy A. Egly, CMA, Pres., 1413 Muland Ct., Joliet 60436, or Luella V. Mitchell, 7920 Eberhart, Chicago 60619.

OFFICERS

President—Cissy A. Egly, CMA, Joliet
 President-Elect—Elaine Kaiser, CMA-A, Oak Forest
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 First Vice-President—Jean Fouts, LPN, Normal
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 Recording Secretary—Mary Lu Ostrowski, CMA, Bloomington
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 Membership Secretary—Vera Murchison, RN, CMA, Glen Ellyn
 Treasurer—Patricia A. Mooney, RN, Galesburg
 Speaker of the House—Luella Mitchell, Chicago
 Vice-Speaker of the House—Pauline Klarich, Peoria
 Parliamentary Advisor—Norma Domanic, LPN, New Lenox
 Chaplain—Jean Berchinski, Homewood
 Historian—Edith Whelan, Oak Lawn
 Chairman, Board of Trustees—Vivian Kraft, CMA-AC, Bloomington

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 Leslie Schwartz, M.D., Chicago
 Robert Hartman, M.D., Jacksonville
 J. M. Ingalls, M.D., Paris, *Liaison to ISMS*
 Allison Burdick, Sr., M.D., Chicago, Emeritus Member

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has

an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

Board of Directors

David S. Fox, Chicago, *Chairman*
 Audley F. Connor, Jr., Chicago
 P. John Seward, Rockford
 Robert R. Hartman, Jacksonville
 Herschel Browns, Chicago

STAFF: Division of Education, Manpower and Convention Services.

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and sys-

tems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Fol-

lowing careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by full-time professional educators; (2) it unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; and (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The eighth Annual Congress will meet in 1980.
2. On behalf of ISMS, perform staff work for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.

4. Organize workshops on techniques of CME—including an unusual "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies.

5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan*, a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbooks on CME Planning—Catalog/Order Form." All publications are free to Illinois physicians—M.D. or D.O.—upon request; just write the title on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.

6. Publish a monthly calendar of Illinois CME activities for *IMJ*.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: nine practicing physicians selected by the ISMS Board of Trustees; and eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school.

Board of Directors

William Lees, Lincolnwood, *President*
Donald F. Pochly, Hines, *Vice-President*
Ward E. Perrin, Chicago, *Secretary*
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Kenneth A. Hurst, Naperville
Alfred J. Kiessel, Decatur
Chase P. Kimball, Chicago
Harold A. Paul, Chicago
Charles Osborne, Springfield
Fred Z. White, Chillicothe
EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.
ASST. EXECUTIVE DIRECTOR: Ronald Cervero, Ph.D.

ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF SEPTEMBER 1, 1979

Alexian Brothers Medical Center—Elk Grove Village
Alfred Adler Institute of Chicago, Inc.
Augustana Hospital—Chicago
Belleville Hospital Association for CME
(Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Champaign County Medical Society
Chicago College of Osteopathic Medicine
Chicago Medical Society
Chicago Neurological Society
Chicago Pediatric Society
Chicago Surgical Society
Christ Hospital—Oak Lawn
Columbus-Cunco-Cabrini Medical Center—Chicago
Community Memorial General Hospital—LaGrange
Copley Memorial Hospital—Aurora
Cook County Hospital—Chicago
DuPage County Medical Society—Lombard

Elgin Mental Health Center
FAB³-CME (Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center)
Chicago
Forest Hospital—Des Plaines
Gottlieb Memorial Hospital—Melrose Park
Grant Hospital of Chicago
Henrotin Hospital—Chicago
Highland Park Hospital
Hinsdale Sanitarium & Hospital
Holy Cross Hospital—Chicago
Illinois Central Community Hospital—Chicago
Illinois Council on Continuing Medical Education
Illinois Heart Association
Illinois Hospital Research & Educational Foundation—
Illinois Hospital Association
Illinois Masonic Medical Center—Chicago
Illinois Society of Allergy and Clinical Immunology
Illinois Society of Ophthalmology and Otolaryngology
Illinois Thoracic Surgical Society

Institute for Psychoanalysis—Chicago
 Kishwaukee Community Hospital—DeKalb
 Little Company of Mary Hospital—Evergreen Park
 Louis A. Weiss Memorial Hospital—Chicago
 Louise Burg Hospital—Chicago
 Loyola University Stritch School of Medicine—Maywood
 Lutheran General Hospital—Park Ridge
 MacNeal Memorial Hospital—Berwyn
 Manteno State Hospital
 Martha Washington Hospital—Chicago
 Mary Thompson Hospital—Chicago
 Memorial Hospital of DuPage County—Elmhurst
 Mercy Hospital & Medical Center—Chicago
 The Methodist Medical Center of Illinois—Peoria
 Michael Reese Hospital & Medical Center—Chicago
 Mount Sinai Hospital Medical Center of Chicago
 Northwestern University Medical School—Chicago
 North Shore Mental Health Association/
 Irene Josselyn Clinic—Northfield
 Northwest Hospital—Chicago
 Northwest Community Hospital—Arlington Heights
 Norwegian-American Hospital—Chicago
 Oak Forest Hospital
 Oak Park Hospital
 Provident Hospital—Chicago
 Ravenswood Hospital Medical Center—Chicago
 Resurrection Hospital—Chicago
 Riveredge Hospital—Forest Park
 Riverside Hospital—Kankakee
 Rock Island Franciscan Medical Center
 Roosevelt Memorial Hospital—Chicago
 Rush Medical College—Chicago
 Sarah Bush Lincoln Health Center—Mattoon
 Sherman Hospital—Elgin
 Silver Cross Hospital—Joliet
 Skokie Valley Community Hospital—Skokie
 South Chicago Community Hospital
 Southern Illinois Medical Association—Belleville
 Southern Illinois University School of Medicine—
 Springfield
 St. Anne's Hospital—Chicago
 St. Anthony Hospital—Chicago
 St. Anthony Hospital—Rockford
 St. Elizabeth's Hospital—Chicago
 St. Elizabeth Hospital—Danville
 St. Elizabeth Hospital—Granite City
 St. Francis Hospital—Blue Island
 St. Francis Hospital—Medical Center—Peoria
 St. Joseph Hospital—Chicago
 St. Joseph Hospital—Elgin
 St. Mary's Hospital—Kankakee
 St. Mary's Hospital—Streator
 St. Mary of Nazareth Hospital—Chicago
 St. Therese Hospital—Waukegan
 SwedishAmerican Hospital—Rockford
 Swedish Covenant Hospital—Chicago
 Tinley Park Mental Health Center
 University of Chicago Pritzker School of Medicine
 University of Health Sciences/The Chicago Medical
 School
 University of Illinois College of Medicine
 Victory Memorial Hospital—Waukegan
 Westlake Community Hospital—Melrose Park
 West Suburban Hospital—Oak Park
 Woodlawn Hospital—Chicago
 Wood River Township Hospital

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with the several local foundations for medical care and is available to serve

their needs on a cost reimbursement basis.

IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*
 Robert P. Johnson, M.D., Springfield, *Vice-President*
 James Laidlaw, M.D., Champaign, *Secretary-Treasurer*
 Audley F. Connor, M.D., Chicago
 Miller Henderson, M.D., Rockford
 Lawrence L. Hirsch, M.D., Chicago

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates in

membership solicitation activities with the American Medical Political Action Committee (AMPAC).

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement with an initial term of five years, and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises four

principal functional divisions: Risk Management and Underwriting, Claims, Policyholder and Public Relations, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

Board of Directors

Phillip D. Boren
Alfred Clementi
Robert Hamilton
J. M. Ingalls
Clifton L. Reeder
Warren D. Tuttle
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Brad Epstein, *Vice Chairman/Treasurer*
David Dreis, *Secretary*
David Whitney, *Delegate*
Ashok (Raj) Paul, *Alternate Delegate*

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Ashok (Raj) Paul
Loyola University
Lori Anderson
Northwestern University
John Diveris
Rush Medical School
Phil Styka

Southern Illinois University
Ray Maciejewski/Tom Nielsen
University of Chicago
Gary Mermel
University of Illinois
Mayra Jimenez

The purposes of the Student Business Session shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Student Business Session shall support the purposes of ISMS as stated in its constitution. The Student Business Session is composed of all student members of ISMS.

Resident Physicians Section

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William E. Golden, *Vice-Chairman/Treasurer*
Linda Hughey Holt, *Secretary-Editor*
William E. Golden, *Delegate*
David Olive, *Alternate Delegate*

House Staff Organization Presidents/Representatives

Christ Hospital/Oak Lawn
Luis E. Augsten, Oak Lawn
East Central Illinois Medical Education Foundation
Ed Warren, Danville

Evanston Hospital
Charles Zinn, Evanston
Illinois Central Community Hospital
Ming Huang, Chicago
Illinois Masonic Medical Center
Elliot M. Levine, Chicago
Illinois Mental Health Institutes
Kumar Moolayil, Chicago
Memorial Hospital of Carbondale
Ronald Johnson, Carbondale
Mercy Hospital and Medical Center
James Fairbairn, Jr., Chicago
Norwegian-American Hospitals, Inc.
Tanacio Villaruz, Chicago

Peoria School of Medicine/Methodist Medical Center
 Thomas Carswell, Peoria
 Rehabilitation Institute of Chicago
 Jay Mendelsohn, Chicago
 Rockford School of Medicine/Swedish American Hospital
 Thomas R. Vikander, Rockford
 Rush-Presbyterian-St. Luke's Medical Center
 Benjamin L. LeCompte, III, Chicago
 St. Francis Hospital/Evanston
 Joseph Calandra, Evanston
 St. Francis Hospital-Medical Center/Peoria
 Dean Gravlin, Peoria
 St. Joseph Hospital
 Lewanzer Lassiter, Chicago
 Swedish Covenant Hospital
 Mohammad Gafoor, Chicago

Veterans Administration/Hines
 Amelia Martinko, Forest Park
 Veterans Administration/Chicago
 Daniel G. Malone, Chicago

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

University of the Health Sciences/The Chicago Medical School
 2020 W. Ogden Ave., Chicago, 60612
 Northwestern University Medical School
 303 E. Chicago Ave., Chicago, 60611
 University of Chicago-Pritzker School of Medicine
 950 E. 59th Street, Chicago 60637
 University of Illinois College of Medicine*
 Chicago Campus—
 1853 W. Polk Street, Chicago, 60612

Loyola University, Stritch School of Medicine
 2160 S. First Ave., Maywood, 60153
 Rush Medical College
 1725 W. Harrison St., Chicago 60612
 Southern Illinois University School of Medicine
 801 N. Rutledge, P.O. 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine.

ALLIED HEALTH EDUCATIONAL PROGRAMS

Accredited by the American Medical Association Committee on
 Allied Health Education and Accreditation

CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
 Mount Sinai Hospital Medical Center
 University of Chicago—Lying-in-Hospital

HISTOLOGIC TECHNICIAN

CHICAGO—Holy Cross Hospital
 Mercy Hospital & Medical Center
 Mount Sinai Hospital & Medical Center
 St. Joseph Hospital
 University of Chicago Hospitals & Clinics
 SPRINGFIELD—Memorial Medical Center
 St. John's Hospital

MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
 CARTHAGE—Robert Morris College
 PALATINE—William Rainey Harper College
 RIVER GROVE—Triton College

MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
 DIXON—Sauk Valley College
 EAST PEORIA—Illinois Central College
 ELGIN—Sherman Hospital Association
 GODFREY—Lewis & Clark Community College
 MORTON GROVE—Oakton Community College
 OLNEY—Richland Memorial Hospital
 PALOS HILLS—Moraine Valley Community College
 QUINCY—Blessing Hospital
 RIVER GROVE—Triton College

MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine
 NORMAL—Illinois State University

MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
 CHICAGO—Central YMCA Community College
 EAST PEORIA—Illinois Central College
 GRAYSLAKE—College of Lake County
 MORTON GROVE—Oakton Community College
 PALOS HILLS—Moraine Valley Community College

MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
 BLUE ISLAND—St. Francis Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Augustana Hospital & Health Care Center
 Grant Hospital of Chicago
 Holy Cross Hospital
 Illinois Masonic Medical Center
 Louis A. Weiss Memorial Hospital
 Mercy Hospital & Medical Center
 Michael Reese Hospital & Medical Center
 Rush-Presbyterian-St. Luke's Medical Center
 St. Anne's Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital Center
 University of Illinois College of Medicine
 V. A. Lakeside Hospital

DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur Memorial Hospital
 St. Mary's Hospital
 EVANSTON—Evanston Hospital
 FREEPORT—Freeport Memorial Hospital
 GENEVA—Community Hospital
 HINES—V.A. Hospital
 HINSDALE—Hinsdale Sanitarium & Hospital
 JOLIET—St. Joseph Hospital
 MAYWOOD—Foster G. McGaw Hosp./Loyola
 University
 NORTH CHICAGO—University of Health Sciences/
 Chicago Medical School
 OAK LAWN—Christ Hospital
 OAK PARK—West Suburban Hospital Association
 PARK FOREST—Governors State University
 PARK RIDGE—Lutheran General Hospital
 PEORIA—Methodist Medical Center of Central Illinois
 St. Francis Hospital
 QUINCY—St. Mary's Hospital
 ROCKFORD—Rockford Memorial Hospital
 St. Anthony Hospital
 Swedish-American Hospital
 SPRINGFIELD—St. John's Hospital
 Sangamon State University
 URBANA—Carle Foundation Hospital
 WAUKEGAN—St. Therese Hospital
 WINFIELD—Central DuPage Hospital
 NUCLEAR MEDICINE TECHNOLOGY
 CHICAGO—Illinois Masonic Medical Center
 St. Mary of Nazareth Hospital Center
 HINES—V. A. Hospital
 PARK RIDGE—Lutheran General Hospital
 PEORIA—St. Francis Hospital-Medical Center
 RIVER GROVE—Triton College
 OCCUPATIONAL THERAPIST
 CHICAGO—University of Illinois College of Medicine
 PHYSICAL THERAPIST
 CHICAGO—Northwestern University Medical School
 University of Health Science/
 Chicago Medical School
 University of Illinois College of Medicine
 RADIOGRAPHER
 ARLINGTON HTS.—Northwest Community Hospital
 BELLEVILLE—Belleville Area College
 CENTRALIA—St. Mary's Hospital
 CHAMPAIGN—Parkland College
 CHICAGO—Central YMCA Community College
 Cook County Hospital
 DePaul University
 Henrotin Hospital
 Illinois Masonic Medical Center
 Louis A. Weiss Memorial Hospital
 Malcolm X Community College
 Michael Reese Hospital & Medical Center
 Provident Hospital & Training School
 Ravenswood Hospital Medical Center
 St. Anne's Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital Center
 South Chicago Community Hospital
 University of Illinois Hospital
 Wright Junior College
 DANVILLE—Lake View Medical Center
 DECATUR—Decatur Memorial Hospital
 DIXON—Sauk Valley College
 EAST PEORIA—Illinois Central College
 ELGIN—St. Joseph Hospital
 EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College
 GLEN ELLYN—College of DuPage
 GRAYSLAKE—College of Lake County
 HINSDALE—Hinsdale Sanitarium & Hospital
 KANKAKEE—Kankakee Community College
 KEWANEE—Kewanee Public Hospital
 MACOMB—McDonough District Hospital
 MALTA—Kishwaukee College
 MOLINE—Lutheran Hospital
 Moline Public Hospital
 MORTON GROVE—Oakton Community College
 NORMAL—Brokaw Hospital
 OLNEY—Richland Memorial Hospital
 PALOS HILLS—Moraine Valley Community College
 PEORIA—St. Francis Hospital
 QUINCY—Blessing Hospital
 St. Mary's Hospital
 RIVER GROVE—Triton College
 ROCKFORD—Rockford Memorial Hospital
 Swedish American Hospital
 ROCK ISLAND—Rock Island Franciscan Hospital
 SOUTH HOLLAND—Thornton Community College
 SPRINGFIELD—Lincoln Land Community College
 Memorial Medical Center
 RESPIRATORY THERAPIST
 CHAMPAIGN—Parkland College
 CHICAGO—Central YMCA Community College
 Malcolm X College
 Northwestern University Medical School
 University of Chicago Hospitals & Clinics
 MOLINE—Lutheran Hospital
 PALOS HILLS—Moraine Valley Community College
 RIVER GROVE—Triton College
 ROCKFORD—St. Anthony Hospital
 SPRINGFIELD—Memorial Medical Center
 RESPIRATORY THERAPY TECHNICIAN
 CHAMPAIGN—Parkland College
 CHICAGO—Metropolitan Group of Hospitals
 Northwestern Memorial Hospital
 University of Chicago Hospitals and Clinics
 KANKAKEE—Kankakee Community College
 MOLINE—Lutheran Hospital
 OAK LAWN—Christ Hospital
 PALOS HILLS—Moraine Valley Community College
 QUINCY—St. Mary's Hospital
 ROCKFORD—Swedish American Hospital
 SPRINGFIELD—St. John's Hospital
 WAUKEGAN—Victory Memorial Hospital
 RADIATION THERAPY TECHNOLOGIST
 CHICAGO—Rush-Presbyterian-St. Luke's Medical
 Center
 ELGIN—St. Joseph Hospital
 EVANSTON—Evanston Hospital
 St. Francis Hospital
 HINES—V. A. Hospital
 ROCKFORD—Swedish American Hospital
 SPECIALIST IN BLOOD BANK TECHNOLOGY
 CHICAGO—Michael Reese Hospital & Medical Center
 Mount Sinai Hospital Medical Center
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 PARK RIDGE—Lutheran General Hospital
 SURGICAL TECHNOLOGIST
 BELLEVILLE—Belleville Area College
 CHAMPAIGN—Parkland College
 EAST PEORIA—Illinois Central College
 MOLINE—Moline Public Hospital
 PALOS HILLS—Moraine Valley Community College
 QUINCY—Blessing Hospital
 RIVER GROVE—Triton College

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Representatives are

elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning

on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

STATE OFFICERS 1979

Governor, JAMES R. THOMPSON, Rep., Chicago
Lieutenant Governor, DAVE O'NEAL, Rep., Belleville
Secretary of State, ALAN J. DIXON, Dem., Belleville
Comptroller, ROLAND W. BURRIS, Dem., Chicago

Treasurer, JEROME COSENTINO, Rep., Palos Heights
Attorney General, WILLIAM J. SCOTT, Rep., Evanston
Clerk of the Supreme Court, CLELL L. WOODS, Springfield

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference

committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 1700, Chicago 60601
One North Old State Capitol Plaza, Springfield 62706
Gregory L. Coler, *Director*

Director's Office

Iris Slack, Deputy Director for Policy and Plans
Shirley Goins, Deputy Director for Program Operations

Thomas Walsh, Deputy Director for Management and Budget

Paul Freedlund, Special Assistant to the Director

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706

160 N. La Salle St., Chicago, 60601

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Ivan Pavkovic, M.D., *Associate Director*

Richard E. Blanton, Ph.D., *Associate Director, Developmental Disabilities Services*

Noble Emde, *Administrator for Management Services*

Edwin Goldman, *Administrator for Community Services & Interagency Affairs*

Roalda Alderman, *Superintendent of Alcoholism & Dangerous Drugs Liaison*

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Alan E. Grischke

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Roalda Alderman

John Meyer

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James Dalzell, *Region 1B Administrator, Peoria*

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DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor

training for previously drug dependent clients as well as clinical staff training.

Since reliable and timely data are essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Section of the Commission continually collects, analyzes and applies data concerning clinical operations (medical work-ups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The Section also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

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DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield, 62701
Jeffrey C. Miller, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

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DEPARTMENT OF PUBLIC HEALTH

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Public Health Laboratories
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134 North 9th Street, Springfield 62706
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STATUTORY BOARDS AND COMMISSIONS

(Allied with Public Health Operations)

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Act, HB 106, 107; P.A. 84-78, 84-79**

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 Lloyd Mosley, Springfield
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 Kenneth Mangan, Ed.D., Jacksonville
 Ralph Naunton, M.D., Chicago
 William Plotkin, Ph.D., Chicago
 Paul Rittmanic, Ph.D., Rockford
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 William P. Johnson, Ph.D., Jacksonville
 Penny Meyers, Skokie
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 Jeanette White, R.D., Chicago
 Jerry Woolley, Chicago

POISON CONTROL CENTERS IN ILLINOIS

For information contact:
 Division of Emergency Medical Services & Highway Safety
 Illinois Department of Public Health
 525 W. Jefferson
 Springfield, 62761
 Phone: (217) 785-2080

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health
 Division of Disease Control
 For information contact:
 Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services Programs
 Illinois Department of Public Health
 Room 150, 535 West Jefferson Street, Springfield 62706
 Phone (217) 782-3303

DEPARTMENT OF REGISTRATION AND EDUCATION

320 W. Washington Street, Springfield 62786
 55 East Jackson Boulevard, Chicago 60604
 Joan G. Anderson, *Director*
 Thomas Ortziger, *Assistant Director*
 Jerry D. Sternstein, *Deputy Director-Licensing*
 Jacob M. Shapiro, *Chief Counsel*
 Louis R. Fine, *Chief Regulatory Officer*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the Department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making

recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Medical Examining Committee

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Mays Maxwell, M.D., East St. Louis
Paul Tullio, D.C., Glen Ellyn
David Fox, M.D., Chicago

Robert Behmer, M.D., Rockford
John Patton, D.O., LaSalle

Medical Disciplinary Board

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Sam Brinkley, D.C., Alton
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Helen R. Beiser, M.D., Chicago
James B. Williams, M.D., Chicago
Raimundo Rodriguez, M.D., Murphysboro

MEDICAL PRACTICE ACT

Service on medical committees—Exemption from civil liability. § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

Practice by person licensed in another state pending examination. § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

- (a) the expiration of 6 months after the filing of such written application, or
- (b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or
- (c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Dispensing drugs or medicine—Label.] § 2d.

Any person licensed under this act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dis-

pensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. *Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972.*

§ 2d5. *Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five

years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service

requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to

graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment.

CONTINUING EDUCATION

Continuing education—Recommendations by Examining Committee]

The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

- (1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:
 - (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
 - (b) Compatible with existing requirements of licensing agencies in other states.
 - (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
 - (d) Compatible with the continuing education requirements developed by national medical specialty societies.
 - (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
 - (f) Provides for differing requirements for licenses engaged in other than direct patient care (ex-

ample: educators, researchers and those engaged in medical administration).

- (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
 - (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
 - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
 - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
 - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
 - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
 - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
 - (g) Procedures for surveying and evaluating the effectiveness of the program.
 - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
- (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
- (4) Develop an advisory panel for each category of licensee to advise and assist the department in developing and application of continuing education criteria, administrative procedures and policy.
- (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality. The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. Added by P.A. 79-1136, §1, eff. July 1, 1976.

REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

Revocation and suspension of license or certificate—Grounds—Limitation—Insanity—Resumption of practice on restoration.]

The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state

hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:
 - (a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;
 - (b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing and regulation of hospitals," approved July 1, 1953, as heretofore or hereafter amended; or
 - (c) an ambulatory surgical treatment center or hospitalization care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control, or
 - (d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or
 - (e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;
2. Conviction in this or another state of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;
3. Gross or repeated malpractice resulting in serious injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury or any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
9. Holding one's self out to treat human ailments by making false statements or by specifically designating any disease, or group of diseases and making false claims of one's skill, or the efficacy or value of one's medicine, treatment or remedy therefore;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state;
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of handbills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business.
14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each.
15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.
16. All advertising of medical business which is intended, or has a tendency, to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety.
17. All advertising of any medicine or of any means whereby the monthly menses of women can be regulated or reestablished if suppressed.
18. Abandonment of a patient.
19. The use of prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.
20. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.
21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.

22. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.
23. Willfully making or filing false records of reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code.
24. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.
25. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.
26. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code.
27. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.
28. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

Amended by P.A. 79-1130, § . [Nov. 2] 21.1075, Pa. 79-13 1434, § eff. Sept. 19, 1976.

Listing of name, title, etc.

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business, absence from,

or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type
Added by act approved July 18, 1967.

MEDICAL DISCIPLINARY BOARD

Illinois State Medical Disciplinary Board.] § 16.02.

There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

- a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willful neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented. In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

- b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.
- c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.
- d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be

authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.

- e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education, hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.
- f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.

The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

- g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:

- (1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.

- h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Suspension or revocation of license or certificate—Investigation—Notice—Hearing.] § 17.01. Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Department shall, through the Board, investigate the actions of any person, so accused who holds or represents that he holds a license or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto the Board under oath within 20 days after the service on him of such notice

and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to the address last theretofore specified by the accused in his last notification to the Department. *Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.] § 17.02. At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, temporarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Subpoena of witnesses—Administration of oath.] § 17.03 The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to administer oaths at any hearing which the Board or Department is authorized by law to conduct. Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Attendance of witnesses and production of books and papers.] § 17.04 Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Record of proceedings.] § 17.05 The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.

Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.

Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.] § 17.06. The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor. If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary status, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license, certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal so to do, the Department may seize the same.

Each certificate of order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order of revocation, suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, and the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Restoration of license or certificate.] § 17.07 At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Review under Administrative Review Act—Venue.] § 17.08 All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a Judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all Judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Order of revocation or suspension as prima facie evidence.] § 17.09 An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;
2. The Director is duly appointed and qualified; and
3. The Board and the members thereof are qualified.

Such proof may be rebutted.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.] § 17.10.

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has

rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.

Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Confidentiality of information received at hearings.] § 17.11 In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Liability for disciplinary action without reasonable basis in fact.] § 17.12 In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.] § 17.13 Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association, or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and use such hearing officers as it deems necessary.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.

Punishment for doing certain acts without license.] § 24. If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments

of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnosticates or attempts to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.

Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.

Physician's Assistants Practice Act

Section 1. The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

Section 2. This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

Section 3. "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

Section 4. No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

Section 5. No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and

engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

Section 6. Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.
2. Submit evidence under oath satisfactory to the Department that:
 - (a) He is 21 years of age or over;
 - (b) He is of good moral character;
 - (c) He has the preliminary and professional education required by this Act;
 - (d) He is free of contagious diseases.
3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.
4. Pay to the Department of Registration and Education at the time of application, an examination fee of \$25. The fee for subsequent renewal of a certificate without lapse shall be \$15.

Section 7. Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall consist of the following:

- (a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and
- (b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

Section 8. Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

Section 9. Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.
2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.
3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.
4. Prescribe rules for examining candidates for a certificate as physician's assistant.
5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

Section 10. Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

Section 11. The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;
2. Gross malpractice resulting in permanent injury or death of a patient;
3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;
4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.
5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;
6. Exceeding the authority delegated to him by his employing physician;
7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

Section 12. No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

Section 13. Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

Section 14. All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

Section 15. All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

Section 16. No person shall use the title or perform the duties of "physician's assistant" unless he is a quali-

fied holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

Section 17. The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness

and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assembly on January 1, 1980.

Section 18. This Act takes effect July 1, 1976.

Section 19. This Act is repealed on June 30, 1981.

DEPARTMENT OF REHABILITATION SERVICES

623 East Adams Street
Springfield, IL 62705
James S. Jeffers, *Director*

The Department of Rehabilitation Services is a statutory agency which determines eligibility for Social Security Disability Insurance, Supplemental Security Income benefits, and Vocational Rehabilitation Services, and operates both educational and medical facilities for

handicapped adults and children. All eligible clients are provided appropriate quality rehabilitation services—evaluation, education, training, guidance and counseling, job placement, medical and support—either directly or indirectly by the Department.

DEPARTMENT OF CORRECTIONS

160 N. LaSalle
Chicago, IL 60601
(312) 793-2955
201 Armory Bldg.
Springfield, IL 62706
(217) 782-4777
Gayle M. Franzen, *Director*

Michael P. Lane, Assistant Director-Adult Division
William O. Gillespie, Assistant Director-Juvenile Division
Laura Jibben, Executive Assistant to the Director
Anthony M. Scillia, Deputy Director-Community Services Division

Jerry Stepaniak, Deputy Director-Management Services Division

Dr. William Craine, Deputy Director-Program Services Division

A. M. Monahan, Deputy Director-Operations Division
Laurel Rans, Deputy Director-Policy Development Division

Samuel Sublett, Accreditation Manager
Russ Mitchell, Public Information Officer
Melody McDowell, Public Information Officer
Marie Hall, Medical Services Administrator

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

Medical Legal Information

The purpose of this section is to present to the Illinois medical community a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish nor imply a standard of care.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although the

Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;

2. The patient may discharge the physician;

3. The relationship may end by mutual consent;

4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician, or does not pay for the services rendered.

When the physician has a reasonable basis to terminate his care of the patient, he must provide the patient with sufficient, reasonable written notice of his intention to withdraw so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

HOSPITAL PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized attorney to examine and make copies of his medical records. With few exceptions, these disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship. With respect to the physician's office records, the statute was amended in 1976 to provide that every physician shall, upon the demand of any patient who has

been treated by him, permit the patient's attorney or physician who is currently treating him to examine and copy all medical records in connection with the treatment of the patient. Psychiatric records are excluded, except when ordered by a Court. The physician to whom the request is directed must respond within a reasonable time and shall be reimbursed by the patient or his representative for all reasonable costs resulting from examining or duplicating the physician's records.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill can result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases the doctor's liability and underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician."

Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done and which demonstrate that the care given met fully the standards of good care as practiced in the community or in similar communities. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make

available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure a consent, in writing, for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician

should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Categories of drugs

under which registration is required are almost identical to those established by the Federal DEA. Registration must be renewed annually.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except willful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee

shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve willful or wanton misconduct. There are cases before the Illinois Courts challenging these grants of immunity and the ISMS is monitoring and cooperating in the defense of these lawsuits; one such case is before the Illinois Supreme Court.

AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the

right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by

whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization," provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

DEATH

Since the controversy generated by the Karen Quinlan case (New Jersey); and the Joseph Saikowicz case (Massachusetts) much has been written about the physician's role in determining death. Some states, Kansas and California, for example, have adopted special legislation in an attempt to "regulate" the legal and medical definitions

of death and to provide so-called, "death with dignity" guarantees. To date, similar laws are not "on the books" in Illinois and, at present, practice in Illinois continues to provide that death occurs when in the judgment of the physician, there has been irreversible cessation of spontaneous vital functions (heart beat and respiration).

CONSENT OF MINORS TO MEDICAL TREATMENT

1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without causing a delay which could adversely affect the condition of such minor's health.

2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that any parent, including a parent who is a minor, may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

3. Birth Control Services for Minors: Birth control

services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor who meets any of the following criteria: is married; is a parent; is pregnant; has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or is referred for such services by a physician, clergyman or a planned parenthood agency.

4. Venereal Disease, Drug Use and Alcoholism—Consent to Treatment By Minor: Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), or from alcoholism may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease or addiction. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with existing regulations. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, or alcohol, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed, except that for alcoholism a physician shall inform the parent if a second episode is addressed.

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois Medical*

Journal. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by

transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which there must be immunization and transferred re-

sponsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the officers, directors and stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield." However, the Corporation can be sued as the employer and the individual doctor-employee can also be sued.

The corporate form does, however, present certain advantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the corporation need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal*

Linscott R. Hanson summarized the advantages of incorporation. Among the major advantages listed were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

There are also some disadvantages or requirements associated with incorporation, as follows:

1. Since a corporation is a separate legal entity, there are certain minimal requirements necessary "to give life and credibility" to the corporate form (record keeping; governance; etc.). Simply declaring yourself a corporation is not enough; the law requires that you operate in accordance with laws governing corporate organizations. Occasionally problems can arise and the physician may incur costs of legal defense in his dealings with the Internal Revenue Service and other governmental bodies as when they challenge his activities carried out in the name of the corporation.

2. Corporations produce other unique costs as well, in-

cluding additional social security taxes; corporate franchise taxes; capital stock and personal property taxes; increased state income taxes; state licensing fees; and other taxes and fees.

3. Corporations usually generate higher administrative and legal costs.

4. Corporations are subjected to many state and fed-

eral laws and regulations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Facilities Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition. At the federal level, renewed efforts are underway to bring all outpatient facilities, including the doctor's office, under the provisions of the law.

This law covers construction or modification plans involving an expenditure of more than \$150,000, or a substantial change in services or bed capacity.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size;

(2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

CURRENT DEVELOPMENTS IN HEALTH LAW

The current health scene is shaped, at least in part, by the adoption of a multiplicity of new laws and regulations, by court decisions and by the methods employed by the many agencies functioning at all levels of government. For example, the Federal Trade Commission continues its aggressive investigations of the health field, even though a Supreme Court decision diluted their efforts to eliminate the use of a Relative Value Scale in setting fees for anesthesiologists.

Unfortunately, litigation based in medical malpractice is increasing once again, stimulated by recent court decisions which expand liability for doctors and hospitals. One set of decisions by the Illinois Supreme Court gave new impetus to the practice of apportioning "fault" among joint-tortfeasors. It heightened the prospect of hospitals and doctors suing each other in third party lawsuits in order to distribute the responsibility for settlements and judgments arising out of negligence lawsuits based on the degree of liability attributed to each named co-defendant. The added stress and costs will not be absorbed easily by the health field. Another recent Illinois Supreme Court decision ruled that radiation (used in therapy) is a product, not a professional service, and, as such, shall be governed by the legal doctrine of *strict* liability. This decision places a higher standard of

care on doctors and hospitals in the circumstances surrounding the administration of radiation therapy. There will exist a kind of "presumption" of negligence in any case resulting in an injury to a patient who has received radiation.

In response to these and earlier developments in the field of health law, the Illinois State Medical Society, by action of its Board of Trustees, developed a program of legal assistance for its members. This Legal Assistance Plan has been approved by the Internal Revenue Service so as to avoid any jeopardy to the tax exempt status of the Society. The Plan may provide legal assistance, funded by the Society, in limited circumstances when the legal issue at stake is of such universal and important consequence as to affect the rights, not only of the individual physician who is a party to the litigation or administrative proceedings, but to all members of the Society. The Executive Committee of the Board acts as a review body to receive written requests for legal assistance and to evaluate each request on its merits. To date, the Society has approved assistance in several cases and has authorized legal counsel to file friend-of-the-court briefs in five lawsuits in which legal issues of considerable significance to Illinois physicians were raised.

Joint Commission on Accreditation of Hospitals 1980 Medical Staff Standards

Principle

There shall be a single organized medical staff that has the overall responsibility for the quality of all medical care provided to patients, and for the ethical conduct and professional practices of its members, as well as for accounting therefor to the governing body.

Standard I: The medical staff shall assure that each member is qualified for membership, and strive to maintain the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic in-depth reappraisal of each staff member. (*Interpretative information accompanying this standard details provisions for qualifications, method of selection, privilege delineation and staff reappointment/reappraisal.*)

Standard II: The medical staff shall be organized to accomplish its required functions. (*Interpretative information accompanying this standard details provisions for medical staff categorization, e.g., active, associate, courtesy, consulting, and honorary staff; provisional and temporary status, medical staff officers, executive committee and departments.*)

Standard III: The medical staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a

means of accountability to the governing body.

Standard IV: The medical staff shall provide mechanisms for the regular review, evaluation, and monitoring of medical staff practice and functions. Such mechanisms shall be designed to maintain high professional standards of care. (*Interpretative information accompanying this standard details provisions for tissue review, pharmacy and therapeutics and medical record functions, blood utilization and antibiotic usage review and other staff functions.*)

Standard V: The medical staff shall participate in a program of continuing education.

The Joint Commission on Accreditation of Hospitals recently revised the Accreditation Manual for Hospitals. A copy of the revised manual has been sent to each accredited Illinois hospital. The medical staff standards are given extensive interpretation, which is not included herein, but should be obtained from the revised manual for a full understanding. The new manual also includes extensive revisions in several other sections, which impact on medical staff activities, and should be examined.

In significant part, this section is reprinted by permission from the "JCAH Accreditation Manual for Hospitals," 1980 edition, pages 93-109.

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81st Illinois General Assembly— The Busiest Ever

When the General Assembly recessed on July 9th, legislative observers quickly began to compute the statistics on the first six-months' activity by the 81st General Assembly. In all, 5,125 separate pieces of legislation were introduced, of which some 31% passed, in 81 legislative days for the Senate and 84 legislative days for the House. This compares with the 3,806 bills which were introduced in the same six-month period by the 80th General Assembly, of which 35% passed.

Many bills did not pass which also were not defeated. They are technically still alive and may or may not see action at some future date. The House has established a category called "Interim Study" into which 754 bills fell. Generally, bills placed in Interim Study were considered too technical to be acted on during the current session and were therefore recommended for additional study. Bills on Interim Study cannot be considered for action until after March 5, 1980. It is important to realize, however, that many bills on Interim Study die there quietly and are never heard from again.

The Senate, however, does not have "Interim Study". In the Senate, bills are assigned to a particular committee and that committee may hold the bill indefinitely, holding hearings on it and acting on it. Generally, however, bills which are held in Senate committees past the summer recess are rarely acted on again. There are presently 701 bills in this category.

Finally, the House has established a new category of consideration this year, the "Spring Calendar." These are bills which were on either first, second, or third reading or on postponed consideration when the House recessed. No one knows for certain how the House will handle these bills when the legislature reconvenes, but some assume that they may stand first for action in January, 1980. There are 245 bills in this category.

In all, this totals to approximately 1,700 bills which the legislature, technically, must consider sometime next year. The vast majority of these bills will never see action and can well be considered defeated. However, the one certainty in dealing with the legislature is that nothing is certain. The rules change at a moment's notice and any one or all of these proposals could well be considered — in addition to all of the bills which may be introduced next year.

During this session, ISMS monitored almost 20% of all bills introduced for consideration. While the Society did not take positions on every one of these bills, many were amended at our request to delete objectionable features, or to make them better proposals. Many consider it frightening that so much of the legislation considered in Springfield has an impact on medicine. With this in mind, it may be appropriate to look at exactly how the Society fared in this last session.

During the last session, ISMS took a formal position on 160 bills of primary interest to Illinois physicians. Of that total, the Society opposed 117 pieces of legislation. Of the 117, 16 were successfully amended to remove ISMS opposition, leaving a balance of 101 bills opposed. Of the 101 bills, ISMS was able to prevent 97 from passing, allowing only 4 bills opposed by physicians to pass. This means that we were successful in stopping objectionable proposals 97% of the time.

ISMS supported 43 bills, passing a total of 30 and not passing 13 proposals. This provides for a success ratio of 70%, a very credible record when one considers the difficulty in passing a bill through the maze also known as the legislative process.

Overall, ISMS held its position, whether for or against legislation, slightly more than 89% of the time — an increase from the 83% record on activity during the last General Assembly. This can be directly attributed to increased physician

participation in the legislative process — participation in the ISMS Key Man Program, quick response to alerts printed in "On The Legislative Scene" are only two examples of the kind of activity seen as evidence of this trend.

There is no end in sight. Each year health care becomes a more and more important issue in government — the private practice of medicine has not and will not go untouched. And presently, no one can accurately predict what the end results will be.

Several issues dominated the General Assembly's consideration during the first session. Included among these were a variety of bills regulating abortions and abortion clinics, amendments to the Controlled Substances Act, enactment of a replacement for the defunct personal property tax, modifications of the generic drug law, and "sunset" legislation. The following is a brief outline of action in these areas.

Abortion

After disclosures by the Chicago Sun Times of widespread abuses by abortion clinics, the legislature was deluged with bills designed to rectify the situation. Some of these bills were introduced by abortion opponents — and were classified largely as nuisance legislation, since their ultimate objective was to end abortion altogether by over-regulating those who would perform them. Other bills were proposed by abortion proponents who wanted to clean up loopholes in Illinois statutes which permitted these abuses to exist. Still others were introduced by a coalition of legislators and came to be referred to as the "reasonable" abortion package. ISMS was peripherally involved in this debate. Our concern dealt not with the question of whether or not abortion should be permitted, but rather with the question of determining a means to safeguard the health and safety of women on whom an abortion would be performed if abortions were to be permitted. To this end, ISMS strongly supported legislation which would modify the way in which complaints against physicians would be handled by the state. Under the law as it existed, any allegations of wrongdoing against a physician were sent to the administrative offices of the Department of Registration and Education. ISMS had evidence that, in at least one case, this information was not submitted to the Medical Disciplinary Board in timely fashion and the physician continued to practice. The recently passed legislation directs that all such complaints be submitted directly to the Board for investigation and action. We be-

lieve that this may streamline the process, in addition to insuring that medical personnel are involved in decisions on the investigation of complaints.

Controlled Substances Amendments

An investigation by the Chicago Tribune into prescription drug abuse resulted in a number of amendments to the Controlled Substances Act, as well as congressional hearings and possible action on the federal level. Two of these were of particular significance. H.B. 1355 requires physicians who dispense controlled substances from their offices (other than by direct administration) to file a triplicate prescription form with the state and places Preludin on the controlled substances list. S.B. 1096 eliminates the "small amounts" exemption from possible prosecution for possession of controlled substances.

Generic Drug Amendments

Reacting to implementation problems of the new generic drug law, a variety of legislators introduced specific amendments. Because these amendments each covered an individual objection and, when taken together, reflected problems with the law in a wide number of areas, the legislature chose not to consider any of the amendments at this time. Rather, all will be considered together in a new proposal which will seek to totally rewrite the law.

Corporate Personal Property Tax Replacement

Following the mandate of the new state constitution, and after nearly 10 years of debate, the legislature enacted a replacement for the corporate personal property tax which was ruled unconstitutional by the state Supreme Court. Even so, formation of a special task force, debate extending the duration of the legislative session, and finally a special session of the legislature were required to enact the replacement tax. As signed by the Governor, the new law calls for a 2.85% tax on the net income of corporations, partnerships, estates, and utilities. In the case of medical corporations, for example, the corporation would pay a 2.85% tax on the checkbook balance, after the payment of all salaries, rent, utilities, and any other operating expenses for the year, at the end of the tax year.

The State Chamber has filed suit to block enforcement of the new law and seeks to have the State Supreme Court overturn it as unconstitutional. To date, there has been no indication as to the probable results of that suit.

Sunset Legislation

• It would appear that one new national legislative trend is enactment of "sunset" legislation — bills which call for repeal of enabling legislation for various state agencies and boards as well as licensing legislation for the various professions. These represent an attempt to streamline government and reduce government spending. A number of such proposals were introduced during the last session, and two different bills passed. The first, H.R. 1944, is called a "pure" sunset bill, in that it calls for the automatic repeal of a variety of licensing acts over a ten-year period. ISMS has opposed this bill, based on our concern that the automatic repeal of acts like the Medical Practice Act may not be in the best interests of the people of Illinois. In addition, a review of sunset experience in other states reveals a number of startling problems. For example, in Colorado, only athletic boards and sanitarians have been affected by sunset. In Florida, legislative warfare broke out following the automatic repeal provision of their sunset law. In addition, some agency budgets were held hostage until other agencies had their enabling laws reenacted. In New Mexico, some regula-

tory boards were strengthened, rather than abolished.

The second sunset bill, S.B. 495, has been termed the "twilight" bill because it does not call for automatic repeal — it creates a commission to review all enabling and licensing laws, making recommendations as to whether they should be repealed, rewritten or left unchanged. In addition, the Commission is empowered to consider all proposed regulatory programs, determining their need, setting standards for the regulation of those licensed or certified by the state, and making recommendations to the legislature regarding licensure of new professions. ISMS supports this legislation as a deliberate and thoughtful attempt to provide those good aspects of sunset, while eliminating the negative.

The following is a brief status report on legislation of major interest to ISMS members. Included is the bill number, a brief synopsis, the ISMS position, and the bill's status. For further information on any of these proposals, contact the Governmental Affairs Division, Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois, 60603.

BILL #	DESCRIPTION & ISMS POSITION (<i>Italic</i>)	STATUS AS OF 9/22/79
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DRUGS

HB 1127	The DES Act. Requires IDPH to establish regional screening programs & maintain voluntary registry of women who took DES during pregnancy. Provides assistance to persons or their offspring who were exposed to DES. <u>No opposition.</u>	Signed 9/14/79
HB 1155	Amends Pharmacy Practice Act; deletes two signature requirement on form permitting generic drug substitution. <u>ISMS Legislation.</u>	Study Calendar of House
SB 107	Creates Act relating to use of chymopapain; authorizes use under selective circumstances. <u>Opposed.</u>	Signed 8/10/79
SB 478	Prohibits preprinting of prescription blanks where prescribed drug is preprinted or where "may not substitute" box is pre-checked. <u>Opposed.</u>	In Senate Public Health Com.

<i>BILL #</i>	<i>DESCRIPTION & ISMS POSITION</i>	<i>STATUS AS OF 9/22/79</i>
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SB 1096	Requires physicians who dispense from their offices to keep accurate and detailed records. Allows physician to administer controlled substances in his office. <u>Support as amended.</u>	Signed 9/7/79
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EMERGENCY MEDICAL CARE

HB 1539	Requires IDPH to license & regulate medical centers which treat injuries or acute medical conditions on an outpatient basis only. <u>Opposed in present form.</u>	Study Calendar of House
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HB 1623	Prohibits IDPH from requiring Advance Life Support/ Mobile Intensive Care System to provide more than one EMT-P on vehicle. <u>No opposition as amended.</u>	Signed 9/22/79
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HB 2227	Requires establishment of statewide Emergency Medical Services Program administered by IDPH; empowers IDPH to license & regulate ambulances. <u>Opposed in present form.</u>	Study Calendar of House
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HB 2685	Requires emergency room have an English speaking doctor on staff at all times. <u>Opposed.</u>	Study Calendar of House
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INSURANCE & REIMBURSEMENT

HB 7	Mandates the inclusion of chiropractic coverage in all BC/BS policies. <u>Opposed.</u>	Study Calendar of House
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HB 410	Identical to HB 7 — <u>Opposed.</u>	Tabled
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HB 746	Mandates the inclusion of podiatric coverage in all BC/BS policies. <u>Opposed.</u>	House Spring Calendar
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HB 1011	Mandates the independent insurance reimbursement of clinical social workers. <u>Opposed.</u>	House Spring Calendar
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SB 8	Requires Director of Insurance to review & approve health care service plan contracts. <u>Support.</u>	Signed 9/16/79
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SB 81	Requires insurance companies and service plan corporations which deny claims as medically unnecessary to allow appeal & peer review of such decisions. <u>No opposition as amended.</u>	Tabled
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SB 689	Requires insurance plans which include optometric services to cover optometrists. <u>No opposition as amended.</u>	Signed 9/7/79
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<i>BILL #</i>	<i>DESCRIPTION & ISMS POSITION</i>	<i>STATUS AS OF 9/22/79</i>
SB 1238	Specifies level of coverage for both in and outpatient psychiatric care — specifies fees. <u>Support.</u>	Conf. report submitted Possible action in fall
SB 1280	Reduces psychiatric coverage in State Employee Ins. Plan. <u>Opposed.</u>	In Senate Insurance Com.
SB 1326	Requires reimbursement of podiatrists at same level as physicians. <u>Opposed.</u>	In Senate Public Health Com.
<i>LICENSING & REGULATION</i>		
HB 166	Creates Midwifery Practice Act. <u>Opposed.</u>	Study Calendar of House
HB 249	Remove option that Blood Bank Director be certified by American Board of Pathology. <u>Opposed in present form.</u>	In Senate Public Health Com.
HB 564	Allows Dept. of Corrections to employ physician's assistants using 1:1 ratio. <u>No opposition.</u>	Signed 9/16/79
HB 856	Permits certification of pupils for special activities or modified PE by a chiropractor. <u>Opposed.</u>	Study Calendar of House
HB 1004	Makes the requirement that silver nitrate be placed in each eye of newborn permissive. <u>Opposed in present form.</u>	Study Calendar of House
HB 1025	Rewrites Ill. Nursing Act. <u>Support.</u>	Amendatory Veto 9/21/79
HB 1660	Defines chiropractic & practice thereof. <u>Opposed.</u>	Study Calendar of House
HB 1688	Requires examination of applicants who seek to practice medicine for knowledge of nutrition. <u>Opposed.</u>	In Senate Public Health
HB 1786	Amends School Code to require a complete vision exam by optometrist or ophthalmologist. <u>Opposed.</u>	Tabled
HB 1908	Abolishes use of blood replacement fees. <u>Support as amended.</u>	Vetoed 9/16/79
SB 1167	Abolishes use of blood replacement fees. <u>Support as amended.</u>	Signed 9/7/79
HB 2225 & SB 1223	Authorizes the use of P.A.'s by jail or prison health facilities using 1:1 ratio. <u>No opposition as favorably amended.</u>	House Spring Calendar Vetoed 9/16/79
HB 2406 & SB 1007	Increase professional licensing fees — includes physicians. <u>Opposed.</u>	Tabled
HB 2531	Creates Applied Behavioral Scientists Regis. Act. <u>Opposed.</u>	House Spring Calendar
HB 2710	Licenses practice of Orthotics & Prosthetics. <u>Opposed.</u>	House Spring Calendar

BILL #	DESCRIPTION & ISMS POSITION	STATUS AS OF 9/22/79
HB 2771	Increases licensing fees — including physicians. Provides for public members on occupational committees. Increases compensation of com. members. <u>Opposed.</u>	In Senate Insurance Com.
SB 144 & SB 385	Certifies hearing aid specialists. <u>Opposed.</u> Certifies hearing aid specialists. <u>No opposition as amended.</u>	In Senate Insurance Com. In Senate Insurance Com.
SB 645	Increases licensing fee for private users of radioactive materials, includes physicians. <u>Opposed.</u>	In Senate Insurance Com.
SB 708	Requires a one time only registration fee of \$40 to obtain state controlled substance registry number. <u>ISMS legislation.</u>	Vetoed 9/11/79
SB 728	Regulates practice of acupuncture. <u>ISMS legislation.</u>	In Senate Public Health
SB 835	Regulates & licenses occupational therapists. <u>Opposed.</u>	Study Calendar of House
MALPRACTICE		
HB 542 & HB 784	Remove contributory negligence as a bar to recovery in civil actions. <u>Opposed.</u>	Study Calendar of House
HB 785	Allows awarding of punitive damages for wrongful death. <u>Opposed.</u>	Tabled
HB 786	Provides the right to recover for loss of society as well as for pecuniary injuries in wrongful death. <u>Opposed.</u>	Tabled
HB 787	Allows negligent persons to share in compensation for wrongful death & pecuniary injuries. <u>Opposed.</u>	Study Calendar of House
HB 1388	Two year statute of limitations. <u>ISMS legislation.</u>	Tabled
HB 1389	Makes attorney liable for untrue statements made by his or her client. <u>ISMS legislation.</u>	Tabled
HB 1390	Prescribes the evidence necessary to establish the standard of acceptable professional practice in medical malpractice actions. <u>ISMS legislation.</u>	Tabled
HB 1391	Allows counterclaims against plaintiff & attorney for malicious prosecution. <u>ISMS legislation.</u>	Tabled
HB 2317 & SB 632	Extends confidentiality of certain medical records to physician owned inter-insurance exchanges. <u>ISMS legislation.</u>	Tabled Signed 9/7/79
HB 2441	Extends current statute of limitations. <u>Opposed.</u>	Study Calendar of House
SB 730	Includes as victims of aggravated battery the employee or agent of a hospital emergency room harmed in ER. <u>ISMS legislation.</u>	Tabled

BILL #	DESCRIPTION & ISMS POSITION	STATUS AS OF 9/22/79
SB 731	Provides immunity for physicians who respond to life threatening emergencies in hospitals. <u>ISMS legislation.</u>	In Senate Judiciary I Com.
SB 756	Allows person to maintain an action for wrongful death for a fetus. <u>No position as amended.</u>	Signed 9/22/79
MISCELLANEOUS		
HB 705	Establishes Div. of Investigation in Dept. of Law Enforcement to investigate Public Aid fraud. <u>No oppos. as amended.</u>	Signed 9/22/79
HB 841	Allows patients to receive explanation of total medical bill. <u>No opposition as amended.</u>	Amendatory Veto 9/14/79
HB 882	Allows treatment of minors for alcohol use — parental notification required — if such notification would jeopardize treatment, parents notified within 3 months. <u>ISMS legislation.</u>	Signed 9/19/79
HB 1219	Create Illinois Institute of Health. <u>Opposed.</u>	Study Calendar of House
HB 2109 & HB 2110	Gradually abolishes office of coroner; replaces with medical examiners. <u>ISMS legislation.</u>	Study Calendar of House
HB 2112	Creates county health service planning boards. <u>Opposed.</u>	Study Calendar of House
HB 2135	Prohibits fertilization outside of mother's womb. <u>Opposed.</u>	Study Calendar of House
HB 2224 & SB 872	Requires health manpower impact note on proposed laws requiring state or local agencies or private health enterprises to provide special medical and/or health services. <u>No opposition.</u>	House Spring Calendar Vetoed 9/22/79
HB 2273	Allows use of tissues or cells obtained from a dead fetus or dead premature infant whose death did not result from an induced abortion. Parental consent required. <u>Support as amended.</u>	Signed 9/21/79
HB 2424	Requires medical vendors pay for cost of preparing record if they challenge IDPA decision. <u>Opposed.</u>	Tabled
SB 715	Allows U of I hospital to collect charges for professional services rendered by Univ. physicians & dentists & use funds for general benefit of the Univ. <u>Support as amended.</u>	Signed 9/14/79
SB 1314	Transfers administration of Division of Services for Crippled Children from U of I to Bd. of Vocational Rehab. Creates medical advisory committee. <u>Support as amended.</u>	Vetoed 9/16/79

Convention Handbook



INTERIM MEETING '79

Holiday Inn
Decatur, Illinois

Members of the House of Delegates

Delegates and Alternate Delegates to the Illinois State
Medical Society

Officers of County Medical Societies

Committees of the House of Delegates

ISMS Delegation to the American Medical Association

Schedule of Meetings

Resolutions

Members of the 1979

Interim Meeting

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	Harold J. Lasky	1980	Twelfth District	Joseph Perez	1980
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	Joseph Sherrick	1980			
	Cyril C. Wiggishoff	1982			

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Delegates and Alternate Delegates to the Illinois State Medical Society

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DOUGLAS	Humberto Mondul	Robert Arrol			
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			STUDENTS	David Whitney	Ashok (Raj) Paul
			HOUSESTAFF	William E. Golden	David Olive

Cook County Delegates

Delegates

Aaronson, Donald
 Andelman, Samuel L.
 Andersen, James H.
 Blankshain, Richard
 Bogen, Gilbert
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 Brislen, Andrew J.
 Brown, Finley W., Jr.
 Budrys, Stanley
 Burkhead, Howard C.
 Chamberlain, Danford O.

Ciskoski, Ronald J.
 Costanzo, Vincent A.
 Cross, Roland R.
 Czeisler, Tibor
 DesRosiers, Raymond J.
 DeYoung, Willard
 Diffenbaugh, W. G.
 Falloon, Edwin L.
 Filipowicz, Roman I.
 Fischer, Arthur
 Fish, William
 FitzGibbons, James P.

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 Flanagan, C. Larkin
 Frankel, Jerome J.
 Freda, Vincent C.
 Fredrick, Earl Jr.
 Friefeld, Nathan
 Gertz, George
 Goldstein, Henry
 Gonzales, Martin
 Green, Martin W.
 Guerrero, Severo K., Jr.

Hamilton, Robert C.
 Harrod, John
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 Hoban, Eugene
 Hoeltgen, Maurice
 Horton, Loren B.
 Hrejsa, Allen C.
 Hutchison, William A.
 Hyde, John S.
 Jacobs, W. Francis
 Jensen, Harold

Jirka, Frank J., Jr.
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 Kalsch, Harry E.
 Kaz, Alex H.
 Kirschenbaum, M. Barry
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 Kowal, Roland A.
 Kozak, John A.
 Kunis, Arthur
 Kwinn, Frank C.
 Lagorio, George L.
 Lobraico, Rocco V., Jr.

Alternate Delegates

Ahstrom, James, Jr.
 Armstrong, Claesa
 Banuchi, Fedor F.
 Barber, Frederick
 Bartolome, Juanita
 Beck, Charles A.
 Berg, Max
 Bild, Sidney
 Borelli, Nelson
 Branovacki, Eugene
 Brown, Murray C.

Burdick, Allison L., Sr.
 Cermak, Miles
 Chaljub, Najib
 Christensen, Eldis M.
 Constantaras, Alexander
 Cucco, Ullisse P.
 De Trana, Frank A.
 Diaz, Alfonso
 Fagan, Peter T.
 Farah, George S.
 Forkosh, David
 Forman, Max

Gardner, Philip M.
 Gianasi, Charles
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 Gnade, Gerard R.
 Goodman, Harold
 Graham, James
 Greville, Warwick
 Gurney, Clifford W.
 Handler, Jerome L.
 Head, Louis
 Henry, Harvey

Hollett, Alan M.
 Hussey, Frank L., Jr.
 Jaffe, Harry J.
 John, Thomas
 Jones, Richard
 Kass, Harold M.
 Kerr, William D.
 Knudson, John A.
 Koch, Donald
 Konecny, Philip
 Landau, Richard L.

Lipsich, Michael
 Lucina, Pedro A.
 McCabe, Mary Joan
 Meccia, Donald
 Meyenberg, John
 Mikhail, Kamel A.
 Muehrcke, Robert C.
 Murphy, Thomas E.
 Murray, Meredith
 Mustell, Robert R.
 Nikurs, Lydia
 Nourbakhsh, M.

Delegates

Lounsbury, B. Franklin
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 Marcus, Anna A.
 Markoutsas, George C.
 Marshall, William
 Meisenheimer, Martin P.
 Nemecek, Raymond W.
 Neskodny, J. F.
 Odiaga-Garcia, Ignacio
 Okner, Henry B.

Olivar, Adriano
 Ostrowski, Fabian
 Patlak, Erwin M.
 Perritt, Richard
 Peterson, Arthur R.
 Petty, David T.
 Quinlan, Donald
 Razim, Edward A.
 Reeder, Clifton L.
 Rice, C. Malcolm, Jr.
 Romanus, Raymond J.
 Rothstein, David A.

Ruane, Michael
 Ruzich, Stanley
 Sarley, Vincent C.
 Saxena, Virendra S.
 Schifano, Joseph
 Schimel, Samuel J.
 Sedlak, Frank
 Shapiro, Maynard I.
 Shaw, Richard
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 Suckow, Earl E.
 Sugar, Sam J.
 Tansey, William J.
 Thompson, J. Robert
 Thrasher, Irving D.

Tovar, Jorge
 Treister, Michael R.
 Turner, George C.
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 Ungar, Jacob
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 Weingarten, Charles Z.
 Williams, Jack
 Xydakis, Stephanos A.

Alternate Delegates

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 Pantone, Anton M.
 Pedroso, Aldo F.
 Pill, Michael P.
 Pleotis, Peter
 Podzamsky, George
 Poma, Pedro A.

Prombo, Marjorie P.
 Pustelnikas, Anthony
 Rebendel, Marek B.
 Rodriguez, Ignacio
 Rogin, Alan
 Rosenzweig, Oscar
 Roy, Shirley
 Saltiel, Isaac
 Santos, Antonio
 Saulys, Vacys
 Schwartz, Franklin
 Schwartz, Malcolm

Schuetz, John N.
 Seed, Randolph
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 Stopka, John E.
 Strohl, Lee H.
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Talso, Peter J.
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Officers of County Medical Societies

1979

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No Organized County Society		Joint County Societies
Edwards		Cass-Brown
Johnson		Jersey-Calhoun
Marshall		Coles-Cumberland
Menard		Morgan-Scott
Putnam		Henry-Stark
		Saline-Pope-Hardin
		Jefferson-Hamilton
		Will-Grundy

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____ CITY: _____ ZIP: _____

ADDRESS: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

Committees of the House of Delegates

1979 Interim Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedures, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to officers, administration, finances, budgets, economics and peer review.

REFERENCE COMMITTEE B

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs and planning.

REFERENCE COMMITTEE C

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to medical service, scientific matters, education and membership services.

REFERENCE COMMITTEE D

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to governmental affairs, medical-legal, and public relations matters.

ISMS DELEGATION TO THE AMA

Delegates

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack L. Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Joseph Skom, Chicago
Fred A. Tworoger, Chicago

To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)

Allison L. Burdick, Jr., Chicago
Henrietta Herbolsheimer, Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
Charles K. Wells, Mt. Vernon
George T. Wilkins, Granite City

To serve from Jan. 1, 1980 to December 31, 1981
(Elected May 9, 1979)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Theodore Grevas, Rock Island
Jack L. Gibbs, Canton
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago

Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, Harrisburg

Delegation Chairman: Herschel Browns; Secretary: Theodore Grevas

Alternate Delegates

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Robert C. Hamilton, Chicago
Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Lee Johnson, Litchfield
Maynard I. Shapiro, Chicago
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1979 to Dec. 31, 1980
(Elected April 5, 1978)

Andrew J. Brislen, Chicago
Alfred Clementi, Arlington Heights
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford
Boyd McCracken, Greenville
Clifton L. Reeder, Chicago

To serve from January 1, 1980 to December 31, 1981
(Elected May 9, 1979)

Robert Hamilton, Chicago
Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Lee Johnson, Litchfield
Harold Lasky, Chicago
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago

ILLINOIS STATE MEDICAL SOCIETY

SCHEDULE OF MEETINGS

INTERIM HOUSE OF DELEGATES

November 10-11, 1979

**Holiday Inn
Decatur, Illinois**

Saturday, November 10, 1979

9:30 a.m.	Delegates Registration Opens
10:00 a.m.	Meeting of Reference Committee Personnel
10:45 a.m.	District Caucuses
11:00 a.m.	Delegates Check-in with Credentials Committee
12:00 noon	House of Delegates Meeting
1:30 p.m.	Reference Committee Meetings
6:00 p.m.	Public Affairs Reception
8:00 p.m.	AMA Delegation Meeting

Sunday, November 11, 1979

8:00 a.m.	District Caucuses
9:00 a.m.	Delegates Check-in with Credentials Committee
9:30 a.m.	House of Delegates Meeting

Resolutions

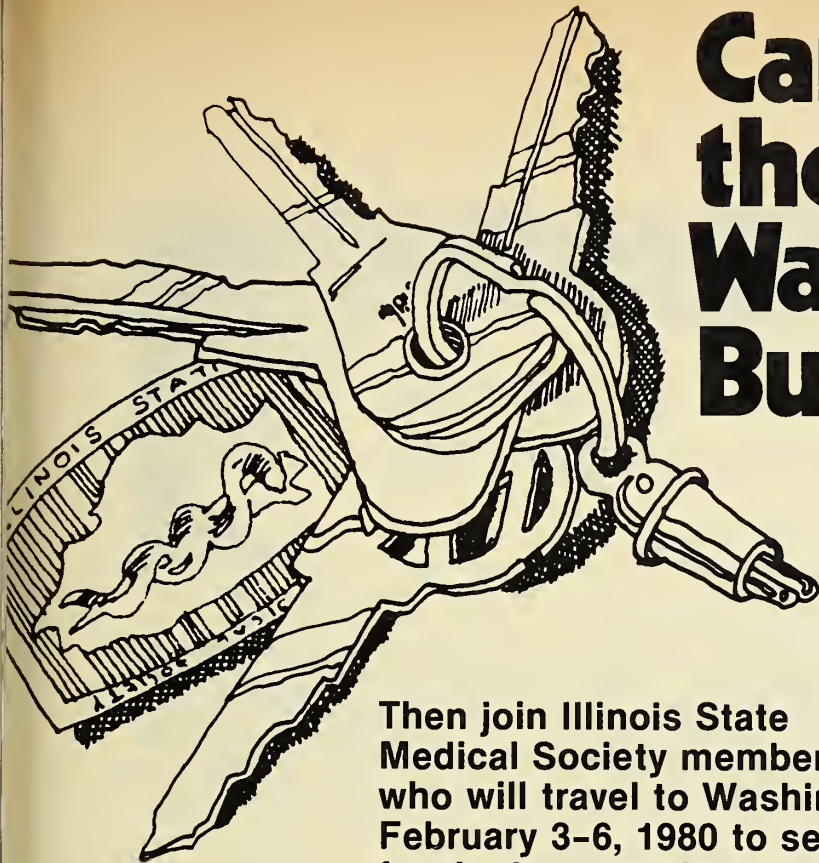
November, 1979, Interim Meeting House of Delegates

The following resolutions were received at ISMS headquarters by September 8 and, according to provisions of the bylaws, are printed in IMJ by title and subject. As a result of recent action by the House of Delegates, the Committee on Rules and Order of Business is responsible for recommending whether or not resolutions submitted by individual delegates will be considered by the House at an interim session or held over for the next annual meeting. This year the committee recommends only that Resolution 79N-2 be accepted for consideration this session.

Final deadline for resolutions was October 13. At this writing, it is anticipated that other resolutions will have been submitted and accepted for consideration before that deadline. These will be included in the Delegates' Packet of materials.

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>
79N-1	Samuel J. Schimel, M.D., for the Chicago Medical Society	Recognition of Physicians' Assistants
79N-2	Lawrence L. Hirsch, M.D., for the Chicago Medical Society	ISMS Judicial Panel
79N-3	H. Frank Holman, M.D., for the St. Clair County Medical Society	Safeguarding the Human Rights of the Illinois Physician

Can't find the key to Washington Bureaucracy?



Then join Illinois State Medical Society members who will travel to Washington February 3-6, 1980 to search for the key together.

Come face to face with key congressional staff members who help write new laws.

Confer with HEW policymakers who write the regulations that implement the laws.

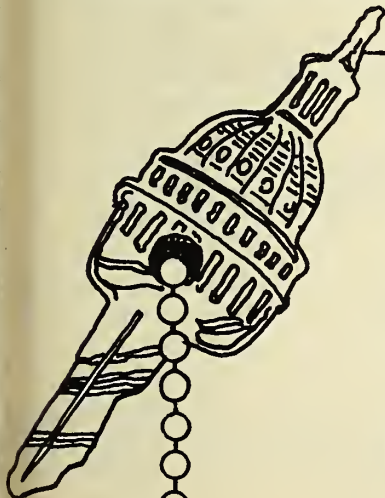
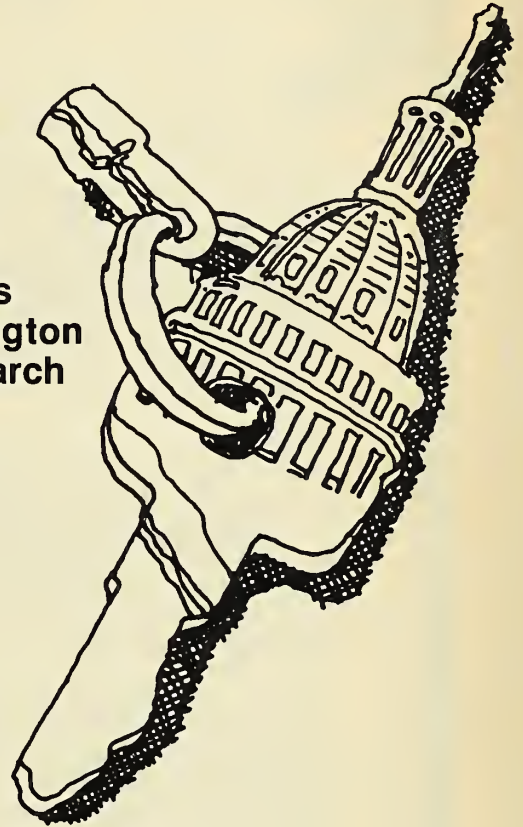
Discuss timely issues with the Illinois congressional delegation.

At the same time

Join a special ISMS tour of key Washington landmarks.

See a performance at the Kennedy Center for the Performing Arts.

Stay at the centrally-located Loew's L'Enfant Plaza Hotel.



SIGN ME UP! I want to attend the 1980 Washington Roundup.

My spouse _____ children _____ will also be attending.

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Address _____

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Return this form to: Governmental Affairs Division
Illinois State Medical Society
55 E. Monroe, Suite 3510
Chicago, Illinois 60603

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

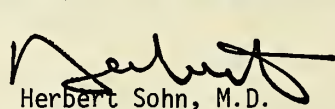
Dear Colleague:

Soon campaign volunteers for candidates for state, federal and local office will be ringing your doorbell asking you to sign nominating petitions for their candidate. Some citizens are reluctant to sign these petitions because they feel that this somehow commits them to supporting the candidate whose name appears on the petition. Others who consider themselves members of one political party or another won't sign because the candidate named belongs to a different party and they thus feel that they have compromised their principles. Both of these arguments are false---signing a nominating petition merely says that a registered voter living within the geographic limits required by law would like to see the name of the candidate listed on the petition appear on the primary election ballot.

I want to call your attention to the term which I used above -- "registered voter." The easiest kind of political action which physicians or other citizens can become involved in -- that of signing nominating petitions -- is prohibited to those who haven't become registered voters. In Illinois, nearly 8 million persons are considered qualified to vote. This means that they have satisfied age and residency requirements. Of that number, less than 6 million have actually registered and are thus eligible to participate in the election process.

The time to register to vote is now. And the process is easy. Call your County Clerk's office. Ask where you have to go to register -- sometimes it's only as far as your own village hall. Ask what evidence you have to present of voter qualification -- sometimes all you need is your driver's license. By acting now, you will be a legally registered voter when the petition circulators begin their rounds. You will be able to become involved in the most basic form of political action in existence. You may even be able to insure that a person you believe will make a good legislator or county sheriff or mayor or states' attorney will be able to take his case to the people because he will officially be a candidate for office.

Many of us complain about our officeholders---they're unqualified---they're unresponsive---they don't understand our problems. In answer, I can only reuse an old statement: "If you're not part of the solution, you're part of the problem."


Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 6, 1979.

Case Report

Mucocele of the Appendix

Dr. David Mendelowitz: A 70-year-old woman came to the emergency room reporting obstipation of five days' duration. Three days earlier, she had developed right lower quadrant pain which was intensified by two self-administered enemas. Nausea and vomiting were absent. The only significant past history was colonic diverticula, documented by barium enema in 1975.

Physical examination included normal vital signs. An ill-defined mass was present in the right lower quadrant of the abdomen, with marked tenderness and rebound. Bowel sounds were diminished and the abdomen appeared mildly distended. Rectal examination revealed tenderness on the right. The white blood cell count was 22,000. Abdominal X-rays were negative and the chest X-ray was normal.

The patient was admitted with a presumptive diagnosis of acute diverticulitis. Intravenous fluids were administered, along with antibiotics. The following morning, she was slightly more tender and an exploratory laparotomy was performed. At the time of operation, a large mucinous mass was found at the tip of the cecum, as well as mucinous material adherant to the terminal ileum, appendix, and scattered throughout the remaining portions

of the abdominal cavity. A right hemicolectomy was performed, including the appendix.

Surgical Sections Described

The histologic sections from this case show a mucinous cystadenoma of the appendix. The wall of the appendix demonstrates considerable inflammation. There are delicate papillary fronds, and tall columnar cells producing mucin. The nuclei in the cells are more flattened and cuboidal. This change in architecture probably represents distension of the appendix from the mucin and alteration in the preexisting papillary architecture. This is consistent with the diagnosis of mucinous cystadenoma of the appendix. The appendix was ulcerated and perforation had occurred. This was evident from the presence of mucinous lakes within the abdomen.

The lakes of mucin were associated with occasional inflammatory cells, but none of the individual cells were forming glands.

Review of the Literature

Mucocele of the appendix are rare. They were first described in 1847 by Rokitansky, and, in 1884, Werth coined the word pseudomyxoma peritonei, which is often linked to mucoceles of

the appendix. Werth also introduced an inflammatory theory for the production of pseudomyxoma peritonei, although Fraenkel in 1901 was the first to link the appendix with the formation of pseudomyxoma peritonei. Woodruff and McDonald developed a second theory for the production of pseudomyxoma peritonei on the basis of malignant cells and also described two histologic types of mucocèles. Bernhardt and Young, in 1965, were the first to report malignant lymph node metastasis from pseudomyxoma peritonei. Finally, studies of Higa and Wolff and Ahmed have provided the best correlation between the histologic appearance of the lesions and prognosis.

In reviewing the literature, approximately 261 cases have been reported, although mucocèles of the appendix are said to occur once per thousand appendectomies. This incidence comes from a Charity Hospital of New Orleans series where they performed over 10,000 appendectomies, in a 15 year period, and found 13 mucocèles, an incidence of approximately one tenth of a percent.

The surgeon usually discovers this lesion while operating on a patient for some other pathology. A quarter of the patients present with the clinical picture of appendicitis. Some present with a mass of the right lower quadrant, approximately 10-15% of total cases. Occasionally an abnormal radiologic study of the gastrointestinal tract will show an indentation in the cecum, and resulting in laparotomy for cecal carcinoma at which time a mucocèle is found. Rarely, patients present with massive abdominal enlargement and are found to have pseudomyxoma peritonei, and mucocèle of the appendix.

Pathophysiology

In terms of the pathophysiology and the histologic description of mucocèles, Higa and Wolff and Ahmed feel that the term "mucocèle" should only be used in a descriptive sense, that is, an appendix that is dilated and filled with mucinous material. A mucocèle of the appendix can arise in four ways. The first, the retention cyst, is somewhat similar to an obstructive gall bladder where one finds so called "white bile." In this instance the lumen of the appendix is obstructed, and mucus is secreted into the lumen. This produces a retention cyst without any evidence of histologic change in the wall of the appendix. The second entity is mucosal hyperplasia, and this is purely an incidental finding on the part of the pathologist. Usually, upon sectioning the appendix, there is mucous found in the lumen and the epithelium of the appendix will show a very similar histologic

picture as the hyperplastic polyp found within the colon. There will be a kind of papillary appearance with a "saw tooth" profile to the goblet cells. The third entity is the type presented today, a mucinous cyst adenoma. Microscopically, one finds a delicate papillary structure in the lumen of the appendix with slight atypia to the columnar cells, and goblet cells producing mucin. Occasionally, due to distention of the appendix secondary to mucous formation, this kind of epithelial pattern will be flattened and one may lose the papillary structure. However, this change is purely secondary to cystic dilatation and a pressure phenomenon on the epithelium of the appendix. The last entity is the mucinous cyst adenocarcinoma. Here the epithelium, when examined on histologic section, is actually invading the wall of the appendix.

Pseudomyxoma peritonei is often associated with mucocèles. The most common question concerns how this should be treated and in what relationship a pseudomyxoma peritonei develops to mucocèles. However, other pathologic processes in the abdomen (ovarian neoplasms, appendiceal neoplasms, or any mucin-producing gastrointestinal carcinoma) can give rise to this problem.

In terms of treatment of mucocèles, one can correlate therapy quite closely to the histopathology. Simple appendectomy is sufficient for the retention cyst of the appendix, and for mucosal hyperplasia. In the latter case it is an incidental finding where the appendix is only noted to have intraluminal mucin by the pathologist. A mucinous cyst adenoma can be treated, if recognized, by a simple appendectomy. However, a mucinous cyst adenocarcinoma of the appendix requires a cancer operation and an ileocelectomy should be performed.

Differential Diagnosis

The differential diagnosis may be difficult at the time of operation. The gross appearance of retention cysts, and mucinous cyst adenomas (which are benign) and mucinous cyst adenocarcinoma, may be similar. Some have recommended that an appendectomy be performed, that margin evaluation and frozen section histology be obtained, and ileocelectomy performed if a carcinoma is found. However, most surgeons recommend that if the gross appearance is suggestive of malignant disease, a right hemocolectomy should be performed.

It should be noted that when a mucinous cyst adenoma is present, 25% of patients will have other lesions in the colon, either carcinoma or adenomatous polyps. Therefore a thorough sys-

tematic search should be made for such lesions when a mucocele of the appendix secondary to cyst adenomas is found.

What should be done for the patient who has pseudomyxoma peritonei? Treatment is dependent upon the etiology and histopathology of the disease. In our patient with a benign mucinous cyst adenoma, the mucinous lakes are not considered to be a malignant process. This small amount of retained mucin will be resorbed and she should not have any further difficulties.

This is supported by statistics from Higa, who followed seven patients who had pseudomyxoma peritonei. All had on histologic diagnosis of mucinous cyst adenoma. They were followed up to 18 years without any difficulty post-operatively or in later years. In contrast, 75% of patients who have cyst-adenocarcinoma with mucinous material in the abdomen will have recurrent problems even when a cancer operation is performed. These patients have the classic pseudomyxoma peritonei, the so-called "jelly belly," with the multiple adhesions, multiple obstructive processes which require lysis of adhesions and evacuation of the mucin.

Therefore, two categories must be considered in treatment and prognosis: (1) free mucin from

a benign process, for example, a cyst adenoma of the appendix: appendectomy is therapeutic and the prognosis is excellent; (2) free mucin secondary to a cyst adenocarcinoma: therapy should consist of right hemicolectomy, debulking of the residual tumor within the abdomen, if possible. As much of the mucin should be removed as possible because this mucin represents malignant implants in the abdomen. These patients may respond to intraperitoneal alkylating agents. X-ray treatments, and systemic chemotherapy do not seem to be effective. ◀

Bibliography

1. Higa *et al.*: "Mucosal Hyperplasia, Mucinous Cystadenoma, and Mucinous Cystadenocarcinoma of the Appendix," *Cancer* 32:1525, 1973.
2. Wolff, M., Ahmed, N.: "Epithelial Neoplasms of the Vermiform Appendix (Exclusive of Carcinoid). (II — Cystadenomas, Papillary Adenomas, and Adenomatous Polyps of the Appendix)," *Cancer* 37:2511, 1976.
3. Hughes, J.: "Mucocele of the Appendix with Pseudomyxoma Peritonei: A Benign or Malignant Disease," *Ann. of Surgery*, 165:73, 1967.
4. Gibbs, N.M.: "Mucinous Cystadenoma and Cystadenocarcinoma of the Vermiform Appendix with Particular Pseudomyxoma Peritonei," *J. Clinical Pathology* 26:413, 1973.

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Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the *Journal* office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.



Clinics for Crippled Children Listed for December

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 23 general clinics, nine cardiac clinics and two clinics for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Dec. 4 Belleville—St. Elizabeth's Hospital
- Dec. 4 Park Ridge Cardiac—Lutheran Gen. Hosp.
- Dec. 5 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- Dec. 5 Aurora (MM)—Mercy Center for Health Services
- Dec. 5 Hinsdale—Hinsdale Sanitarium
- Dec. 5 Rockford—St. Anthony's Hospital
- Dec. 6 Lake County Cardiac—Victory Mem. Hosp.
- Dec. 6 Sterling—Community General Hospital
- Dec. 6 Litchfield—St. Francis Hospital
- Dec. 6 Effingham—St. Anthony Memorial Hosp.
- Dec. 6 West Frankfort—Union Hospital
- Dec. 7 Division Cardiac—U. of I. at the Medical Center
- Dec. 10 Peoria Cardiac—St. Francis Hospital
- Dec. 11 East St. Louis—Christian Welfare Hosp.
- Dec. 11 Peoria General—St. Francis Hospital
- Dec. 12 Joliet—St. Joseph's Hospital
- Dec. 12 Champaign-Urbana—McKinley Hospital
- Dec. 12 Carmi—Carmi Township Hospital
- Dec. 13 Springfield General—St. John's Hospital
- Dec. 13 Kankakee General—St. Mary's Hospital
- Dec. 13 Rockford—Rockford Memorial Hospital
- Dec. 14 Evanston—St. Francis Hospital
- Dec. 14 Chicago Heights Cardiac—St. James Hosp.
- Dec. 17 Maywood—Loyola Medical Center
- Dec. 17 Peoria Cardiac—St. Francis Hospital
- Dec. 18 Rock Island General—Moline Public Hosp.
- Dec. 18 Peoria General—St. Francis Hospital
- Dec. 19 Aurora—Mercy Center for Health Care Services
- Dec. 19 Springfield Ped-Neuro—St. John's Hosp.
- Dec. 19 Chicago Heights General—St. James Hosp.
- Dec. 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Dec. 20 Bloomington—Mennonite Hospital
- Dec. 21 Chicago Heights Cardiac—St. James Hosp.
- Dec. 21 Kankakee Cardiac—St. Mary's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.
Manati, Puerto Rico 00701

The stress-secretion relationship in duodenal ulcer*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.²



The duodenal ulcer reflects the erosion of a vulnerable mucosa by acid-pepsin secretion.²

The best available evidence^{1,2} suggests that chronic anxiety stimulates acid-pepsin secretion. Also, the development of an ulcer crater in predisposed individuals, or the aggravation of ulcer symptoms, is often associated with a stressful event or situation.¹ Thus, anxiety seems to play an important role in the course and prognosis of the disease.¹

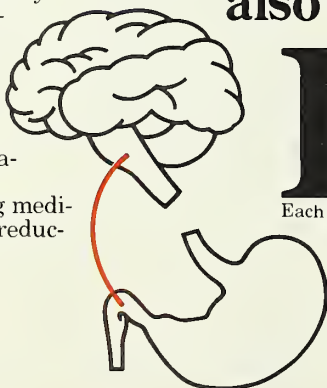
To obtain more comprehensive relief, many duodenal ulcer patients need more than specific, acid-inhibiting medication. They also need reduc-

tion of accompanying anxiety and emotional tension.

References: 1. Isenberg J, Richardson CT, Fordtran JS. Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

MH, Fordtran JS; Philadelphia, WB Saunders Company, 1978, vol. 1, pp. 800-801 2. Sun DCH: Etiology and pathology of peptic ulcer, chap. 27, in *Gastroenterology*, ed. 3, edited by Bockus HL, et al, Philadelphia, WB Saunders Company, 1974, pp. 579-595.

**More than an antisecretory agent...
also acts on accompanying anxiety**



**Adjunctive
Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

antianxiety/antisecretory/antispasmodic

ROCHE

*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on preceding page.

Abstracts of Board Actions

September 15-16, 1979

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

FINANCES/DUES BILLING

Acting on financial matters, the Board:

- Approved a balanced ISMS 1979 revised budget of \$2,224,125, reflecting a \$42,000 increase in both income and expenses over the original '79 budget.
- Transferred management of the Society's Permanent Reserve Funds from Continental Illinois National Bank & Trust Company, Chicago, to Capital Supervisors, Inc., Chicago, an investment management firm.
- Authorized additional study—with expenditures not to exceed \$50,000—to determine how a Society-sponsored carrier could be created to support local physician-sponsored prepayment programs (Individual Practice Associations). A comprehensive report on the ISMS activities will be presented to the House of Delegates in November.
- Approved a 7% increase in *Illinois Medical Journal* black and white advertising rates, and a 5% increase in color rates, effective January 1. The \$12 subscription rate remains unchanged.

ISMS will meet with AMA officials to request that (1) State Society dues collection commissions be doubled; and (2) AMA share half of its first full year's dues with county medical societies to offset new member solicitation and processing costs. Last year, AMA agreed to reimburse those state societies which adhere to its "Criteria for Dues Billing" on the following formula basis—for equitable, share distribution to any component society involved in the billing process:

- 2% of dues received by AMA no later than January 15
- 1.5% of dues received by AMA no later than February 15
- 1% of dues received by AMA no later than March 15
- .5% of dues received by AMA after March 15

While only three of 13 county societies which conduct their own dues billing participated in sharing the AMA commission for early remittance in 1979, several others have expressed interest if the rate is doubled.

Citing excessive processing costs, the Board eliminated from the dues billing form the *medical school designation option* for AMA/ERF allocations. The \$10 allocation now will be appropriated to U.S. medical schools according to historical distribution, with the remaining undesignated portion distributed to Illinois schools in accordance with the size of the current graduating class. ISMS also will notify AMA that it no longer is necessary to mail letters of appreciation to individual members and advise schools of individual contributors. Only 47% of ISMS members had been indicating on dues bills the medical school that should receive their AMA/ERF contribution.

(Continued on page 410)

**Grandpa's
a year older...**



and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years—

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged. Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate—despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic bronchopulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease*; *persons in chronic care facilities*.

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. Adverse reactions include local erythema and soreness at the injection site; low-grade fever occurs occasionally. PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine. Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

More than ever he may need

PNEUMOVAX[®]
(Pneumococcal Vaccine, Polyvalent | MSD)

MSD
MERCK
SHARP &
DOHME

*Please see following page for
summary of prescribing information.*

Copyright © by Merck & Co., Inc., 1979

PNEUMOVAX® (Pneumococcal Vaccine, Polyvalent |MSD)

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature		Pneumococcal Types													
U.S.	1 2 3 4 6 8 9 12 14 19 23 25 51 56														
Danish	1 2 3 4 6A 8 9N 12F 14 19F 23F 25 7F 18C														

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported. Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe

Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials

For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

J9PX12 (DC 7014803)

MSD
MERCK
SHARP
DOHME

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

Obituaries

****Ascher, John Peter**, Tucson, Arizona, died May 2, 1979, at the age of 90. Dr. Gueno was a 1928 graduate of the Loyola University Stritch School of Medicine.

****Coakley, Leo P.**, Elgin, died July 29, 1979, at the age of 78. Dr. Coakley was a 1926 graduate from the Nebraska University School of Medicine.

***Fagan, George E.**, Champaign, died September 30, 1979, at the age of 57. Dr. Fagan was a 1947 graduate of St. Louis University Medical School.

***Gueno, William T.**, E. St. Louis, died September 18, 1979, at the age of 90. Dr. Gueno was a 1928 graduate of the Chicago Medical School.

****Howard, William H.**, Chicago, died September 10, 1979 at the age of 85 Dr. Howard was a 1917 graduate of the Loyola University Stritch School of Medicine.

***Jacobs, Edward Jesse**, Arlington Hts, died October 9, 1979, at the age of 53. Dr. Jacobs was a 1954 graduate of the Northwestern University Medical School.

***Lerner, David G.**, Chicago, died October 3, 1979, at the age of 71. Dr. Lerner was a 1933 graduate of the University of Illinois Medical School.

***Millet, Roscoe Frick**, Macomb, died August 1, 1979, at the age of 74. Dr. Millet was a 1930 graduate from Northwestern University Medical School.

***O'Neill, Paul Joseph**, Alton, died September 20, 1979, at the age of 70. Dr. O'Neill was a 1938 graduate from the University of Illinois Medical School. Dr. O'Neill was formerly on the staffs of St. Anthony and St. Joseph Hospitals and served as a flight examiner for the Federal Aviation Administration.

***Rightman, Bert**, Chicago, died September 13, 1979, at the age of 71. Dr. Rightman was a 1935 graduate of the University of Illinois Medical School.

****Schechter, William**, Elmwood, died September 30, 1979, at the age of 79. Dr. Schechter was a 1924 graduate of the University of Illinois Medical School.

****Schmechel, Alfred R.**, Sun City, Arizona, formerly of Chicago, died September 23, 1979, at the age of 91. Dr. Schmechel was a graduate of Chicago Medical School.

****Schmidtke, John C.**, Elgin, died September 25, 1979, at the age of 53. Dr. Schmidtke was a 1926 graduate from Washington Univ. in Missouri. He had served on the staffs of St. Joseph and Sherman hospitals in Elgin for 40 years.

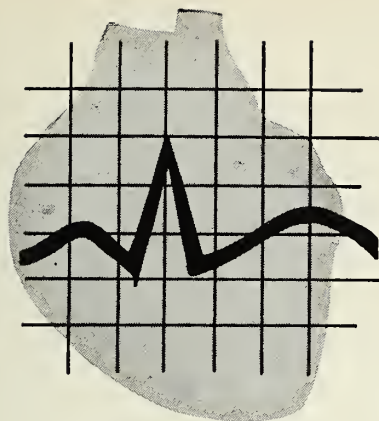
***Smith, Henry A.**, Wheaton, died September 10, 1979, at the age of 81. Dr. Smith was a 1932 graduate from the Chicago Medical School.

***Titus, Joseph Cecil**, Chicago, died October 7, 1979, at the age of 40.

Veach, Earl Allen, Vienna, died October 29, 1979, at the age of 89.

* Indicates ISMS member

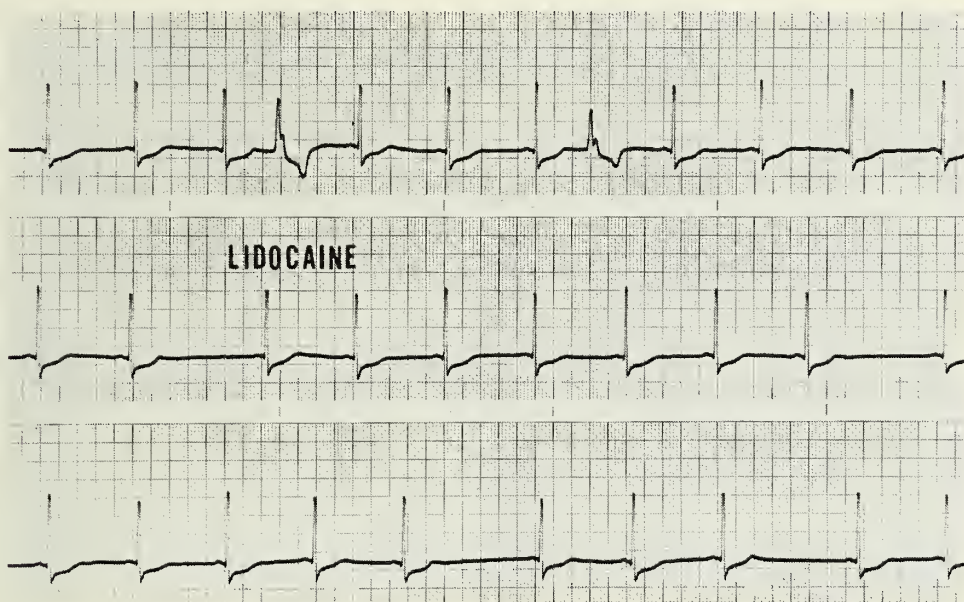
** Indicates ISMS member of the fifty year club



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a 53 year old male patient who gave a history of two myocardial infarctions in the past. He had been able to return to work as a butcher. Recently his chest pains had returned. They were brought on by progressively less and less exertion. These chest pains were retrosternal in origin and radiated to both arms. Although occasionally accompanied by diaphoresis, they were always exertional and always relieved by nitroglycerin. The abnormal finding on his physical examination was a loud atrial gallop (S_4). He was recommended for a coronary arteriogram. The coronary arteriogram showed a totally obstructed right coronary artery as well as significant proximal obstructions in the left anterior descending, ramus intermedius, and a large diagonal artery. Subsequently he underwent quadruple aortocoronary saphenous vein bypass surgery. On the third postoperative day, this arrhythmia was seen. A 100 mg. intravenous lidocaine bolus was given just prior to the second ECG strip.



Questions:

1. The ECG rhythm strip show(s):

- A. Frequent premature ventricular beats.
- B. Atrioventricular Wenckebach block.
- C. Frequent premature atrial beats with aberrant intraventricular conduction.
- D. Non-conducted premature atrial beats.
- E. All of the above.

2. The following statement(s) is/are true:

- A. In a premature atrial beat, the more pre-

mature the ectopic P wave, the longer the PR interval of that beat.

- B. The presence of a compensatory pause favors the diagnosis of premature atrial beats.
- C. Premature atrial beats are not diagnostic of organic heart disease.
- D. Premature atrial beats may lead to the development of atrial fibrillation or atrial flutter.
- E. All of the above.

(Continued on page 428)

New... **Chronulac[®]** (lactulose) Syrup **Rx only**

Each 15 ml. of syrup contains: 10 g. lactulose (and less than 2.2 g. galactose, less than 1.2 g. lactose, and 1.2 g. or less of other sugars).

**restores bowel function
with no evidence of tolerance**

Lactulose Syrup Assessed in a Double-Blind Study of Chronically Constipated Patients

ABSTRACT
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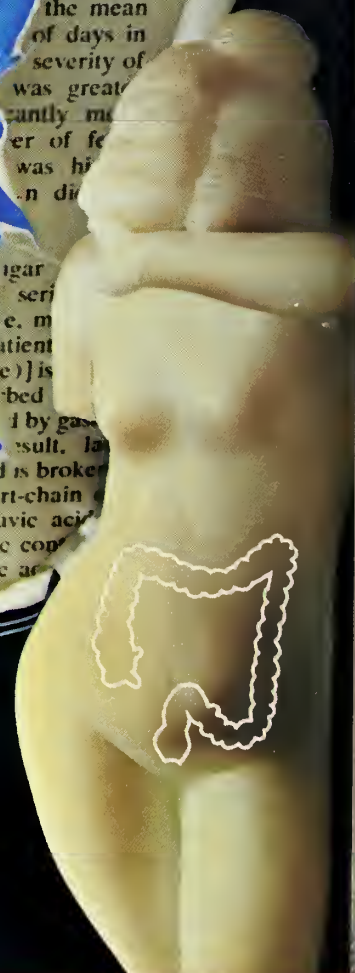
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Significant advance in
the clinical management
of constipation from

Merrell



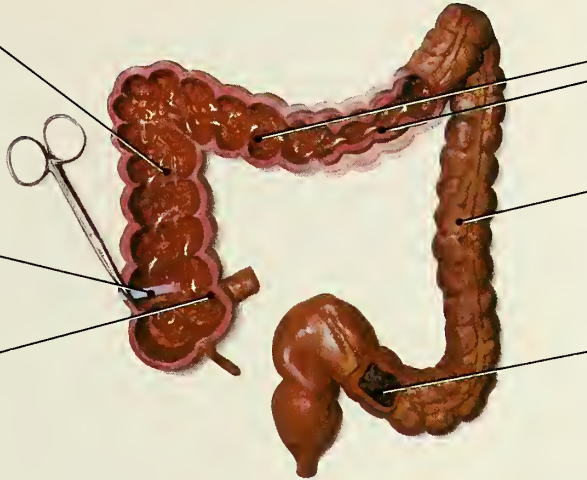
Unique colon-specific non-systemic mode of action

No enzyme capable of breaking lactulose down to its constituent monosaccharides exists in the human small intestine¹. Hence, lactulose passes through the small intestine unchanged and unabsorbed to reach the colon. Within 5 minutes² normal colonic bacteria institute the chain of events illustrated below.³ The repeated stimulus to the colon's own propulsive activity helps restore normal function with no evidence of tolerance.⁴⁻⁷ Twenty-four to 48 hours may be required to produce a normal bowel movement.

3. Degradation to low molecular weight acids markedly increases the number of osmotically active molecules present.

2. The acid metabolites cause a drop in pH.

1. 97% of the Chronulac dose reaches the colon unchanged and bacterial breakdown to low molecular weight acids begins.



4. The acid pH and osmotically assured water content stimulate the colon's own propulsive activity.⁸

5. The colon's natural electrolyte transfer tends to restore a neutral pH and the water content maintains stool softening.

6. A dose-responsive stool of increased weight, volume, and moisture content results⁸ usually within 24 to 48 hours. No evidence of tolerance to the drug has been reported.⁴⁻⁸

Laboratory-monitored freedom from adverse reactions

avoids the potentially harmful effects of the repeated use of traditional laxatives

Laboratory measurements⁷⁻⁹ failed to elicit any drug related changes in blood elements, serum electrolytes, enzyme activity, or blood calcium and magnesium concentrations variously tested in patients and normal subjects who had received lactulose daily for periods up to 6 months. When daily treatment of elderly and debilitated patients must be continued beyond 6 months, it is recommended that serum electrolytes be checked before treatment is continued.

No evidence of tolerance, long-term

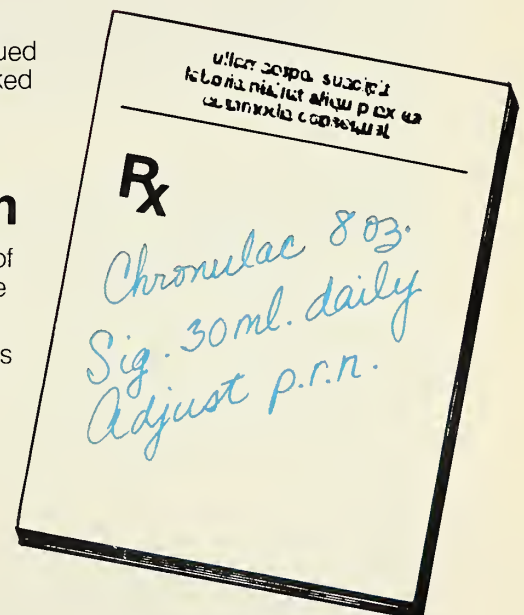
Clinical studies have failed to demonstrate the need to increase doses of lactulose with long-term treatment. Once established, the effective dose can be maintained.

In one study of 82 patients, 57 took daily doses of Chronulac for periods ranging from more than a month up to a year.⁸ No patients developed tolerance to Chronulac. Fifteen patients actually ended the period of treatment on a lower dose than their starting dose.

Double-blind placebo-controlled proof of efficacy

See next page for brief summary of prescribing information.

R_x only



Chronulac®

(lactulose) Syrup Rx only

- restores bowel function with no evidence of tolerance
- avoids the potentially harmful effects of repeated use of traditional laxatives
- colon-specific mode of action—non-systemic
- proven efficacy and safety—even long-term
- available only on prescription

Chronulac® (lactulose) Syrup

CAUTION: Federal law prohibits dispensing without a prescription.

Brief Summary

INDICATION: For the treatment of constipation. In patients with a history of chronic constipation, lactulose syrup (Chronulac) therapy increases the number of bowel movements per day and the number of days on which bowel movements occur.

CONTRAINDICATIONS: Since Chronulac contains galactose (less than 2.2 g./15 ml.), it is contraindicated in patients who require a low galactose diet.

WARNINGS: **Use in Pregnancy** Studies in laboratory animals (mice, rats, rabbits) have not revealed a teratogenic potential of Chronulac. The safety of Chronulac syrup during pregnancy and its effect on the mother or the fetus have not been evaluated in humans. The physician and patient should understand that the possibility that Chronulac might cause damage to the human fetus cannot be excluded. Chronulac should not be given during pregnancy unless, in the opinion of the physician, the possible benefits outweigh the possible risks. **Use in Nursing Mothers** There are no data on secretion of Chronulac in human milk or effect on the nursing infant. **Use in Children** There is insufficient experience to recommend a dose of Chronulac that is safe and effective for treatment of constipation in children. **PRECAUTIONS:** Elderly, debilitated patients who receive Chronulac for more than six months should have serum electrolytes (potassium, chloride, carbon dioxide) measured periodically. Also, since Chronulac contains galactose (less than 2.2 g./15 ml.) and lactose (less than 1.2 g./15 ml.), it should be used with caution in diabetics.

ADVERSE REACTIONS: Initial dosing may produce flatulence and intestinal cramps, which are usually transient. Excessive dosage can lead to diarrhea. Nausea has been reported. **OVERDOSAGE:** There have been no reports of accidental overdosage. In the event of overdosage it is expected that diarrhea and abdominal cramps would be the major symptoms. Medication should be terminated. **DOSAGE AND ADMINISTRATION:** The usual dose is 1 to 2 tablespoonsful (15 to 30 ml., containing 10 g. to 20 g. of lactulose) daily. The dose may be increased to 60 ml. daily if necessary. Twenty-four to 48 hours may be required to produce a normal bowel movement.

Note: Some patients have found that Chronulac may be more acceptable when mixed with fruit juice, water, or milk.

Product Information as of April, 1979

References: 1. Dahlqvist, A. and Gryboski, J.D.: Inability of the human small-intestinal lactase to hydrolyze lactulose. *Biochim. Biophys. Acta* 110:635-636, 1965. 2. Bond, J.H., Jr. and Levitt, M.D.: Investigation of small bowel transit time in man utilizing pulmonary hydrogen (H_2) measurements. *J. Lab. Clin. Med.* 85:546-555, 1975. 3. Hoffmann, K., Mossel, D.A.A., Korus, W., and van de Kamer, J.H.: Investigations on the mode of action of lactulose (β -galactosido-fructose) in the human intestine. *Klin. Wschr.* 42:126-130, 1964. 4. Mayerhofer, F. and Petuely, F.: Investigations regarding the regulation of the intestinal activity in adults with the aid of lactulose (bifidus factor). *Wien. Klin. Wschr.* 71:865-869, 1959. 5. Eustathios, K.G.: The treatment of chronic constipation by lactulose. *Galenos* 11:411-419, 1969. 6. Losner, I.: Lactulose: a clinical study in a chronically constipated geriatric population. *Clin. Med.* 76:24-25, 28-29, 1969. 7. Watson, J.S. and Ebert, W.R.: Lactulose: a new bowel regulator. *Clin. Med.* 76:24-26, 1969. 8. Data on file, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 9. Sanders, J.F.: Lactulose syrup assessed in a double-blind study of elderly constipated patients. *J. Amer. Geriatr. Soc.* 26:236-239, 1978.

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Regulations Suspended Indefinitely

FDA Announces Change In Diagnostic X-Ray System Assembly and Reassembly Regulation

The Food and Drug Administration issued regulations on August 1, 1974, providing that no uncertified components could be assembled into a diagnostic X-ray system, or reassembled when the reassembly was associated with a change of ownership and location of the system, as of August 1, 1979. *That deadline has been rescinded and suspended indefinitely.*

The FDA announcement stated that the deadline extension has been effected because other contemplated or existing agency programs would better improve radiation safety performance of all diagnostic X-ray systems without reducing health care delivery. They are reviewing comments on the extension at this time.

In advising ISMS of this change, the Illinois Department of Public Health has noted that it should be helpful to those using diagnostic X-ray equipment, since new system components may not be necessary, and if not, significant cost containment may be effected.

For further information contact Mr. Maury Neuweg, Chief, Division of Radiological Health (217-782-2342) or Mr. James Kraeger, FDA representative (312-353-5244).

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PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

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SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

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HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

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Student Business Session in Action

Medical Student Scorecard AMA Annual Meeting 1979

Here we shall review and summarize the actions of the AMA House of Delegates pertaining to medical students at the 1979 Annual Meeting held in Chicago. Nearly two-thirds of these initiatives directly resulted from AMA/SBS proposals. These House actions can be placed in three categories; those dealing with medical education, those concerning the role of the student in the AMA, and those related to questions of public concern.

In an action relevant to medical education the HOD supported an SBS resolution encouraging state medical societies to solicit student input when legislation pertinent to students is considered.¹ Due process guidelines were proposed pending the completion of a report by the Board of Trustees.² AMA support was given to national and state efforts to increase financial aid to medical students.³ A proposal asking that the AMA recommend acceptance of either the National Boards, Parts I, II, III or the FLEX for granting a state license to practice medicine was referred to the Board of Trustees for further study.⁴ Also, the AMA Council on Medical Education was asked to consider the newly proposed FLEX in terms of student performance evaluation.⁵ A proposal encouraging alternatives for dealing with emotional problems of medical students was adopted by the House.⁶

A number of actions were taken regarding the student role in the AMA. First, it was determined that completion of an education program or residency shortly before the Annual AMA Meeting would not prohibit student or resident members of AMA Councils from serving during the Annual Meeting.⁷ A medical student position was estab-

lished on the Council on Scientific Affairs,⁸ and voting privileges were granted to student members of AMA Councils at the discretion of the council involved.⁹ To date, all AMA councils have afforded full voting privileges to their medical student members. In addition, several recommendations were offered to expand participation not only by female medical students but also by female physicians in organized medicine.¹⁰

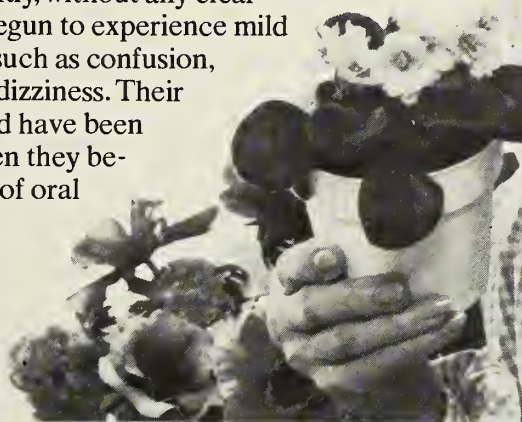
Matters of public concern received much attention from the HOD. The AMA voted to continue monitoring the National Health Service Corps and to continue offering legislation dealing with physician placement practices and selection of areas for physician assignment. The AMA also supported participation by local professional medical societies in NHSC programs.¹¹ The AMA did not adopt any resolution in total opposition to federally funded compulsory health insurance programs. However, the AMA also did not back any of the catastrophic health insurance bills presently pending in congress.¹² The AMA supported SBS opposition to implementation of a "Doctor's Draft" in peacetime.¹³ Statements of AMA concern and support were given to efforts at maintenance of high standards in nursing home care,¹⁴ continuation of appropriate physical education programs for precollege students,¹⁵ rehabilitation and counseling for deinstitutionalized psychiatric patients¹⁶ and continued research into effects of low radiation levels with dissemination of results obtained.¹⁷ All these positions were in response to SBS proposals. Finally, position statements

(Continued on page 372)

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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The "Essentials of Accredited Residencies" Does Your Program Comply?

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey Holt, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

The Liaison Committee on Graduate Medical Education (LCGME) puts forth the "Essentials of Accredited Residencies," an oft-quoted work which serves as a blueprint for approval of residency programs. The "Essentials" are undergoing almost constant revision. The current version, most recently revised in July of 1978, deals very specifically with the issue of the "Hospital-Resident Agreement." You may find that your program does *not* comply with the "Essentials" and in fact you may prefer that it not comply, but it is of interest to find that the guidelines for residency programs deal directly with issues of salary, insurance, and hours.

10. Hospital-Resident Agreement*

A formal agreement in which mutual obligations are defined should be entered into between the hospital and the applicant at the time of his appointment. This agreement must be honorably fulfilled by both parties and when terminated by mutual consent, the hospital should provide a statement of release from the agreement or contract. Contracts for one year, renewable by mutual consent, are preferable.

The Council urges that all inducements, representations, and agreements made with respect to the offer and acceptance of a residency be embodied in the terms of a written agreement which should specify at a minimum the following:

1. The term of the residency.
2. The salary.
3. The conditions under which living quarters, meals, and laundry or their equivalent are to be provided.
4. Whether the hospital will provide professional liability (malpractice) insurance for the resident, or whether he will be expected to provide such insurance at his own cost if he desires this coverage.
5. Whether the hospital will provide hospitalization and health insurance for the resident and his family.
6. Vacation periods.
7. Hours of duty, or the method by which this is to be determined.

8. The content of the educational phase of the residency, including duration and sequence of the specified assignments to clinical, laboratory or ambulatory care facilities.

The residency agreement imposes ethical, moral and legal obligations upon both the hospital and the resident. No residency should be terminated prior to its expiration date without the opportunity for both parties to discuss freely any differences or grievances that may exist.

Under particular circumstances, the hospital or the resident may be justified in terminating a residency prior to the expiration of its term. If the resident fails to perform the normal and customary services of a residency or fails to comply with the reasonable rules that **are** necessary in the orderly operation of the hospital, the hospital may be justified in taking such action. Likewise, a physician should be entitled to rely upon representations with respect to opportunity for educational experience, conditions of service, living quarters, agreed vacation periods, etc., that are made to induce him to apply for the residency.

A breach of the agreement by either a hospital or a resident is not condoned by the Council.

Whenever complaint of such a breach is made, it is the policy of the Council to ask each of the parties involved to submit an explanatory statement. Such statements become a part of the physician's and hospital's records, and are made available upon request to authorized agencies.

In addition to being familiar with the guidelines, residents should consider three aspects of contracts: (1) Many hospitals have no written contract—and lack of a written contract can, on occasion, be to the advantage of a resident. Although the hospital may terminate a resident at short notice, a resident can also leave a program at short notice. The AMA legal advisor for housestaff receives substantial numbers of inquiries from residents wanting out of contract responsibilities as well as from residents who feel their contract was broken by the hospital.

(2) Simply *having* a contract offers a resident little real protection against violations. The LCGME has not chosen to make an issue of enforcing resident contracts; most residents are

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unable or unwilling to be labelled troublemakers by protesting contract violations.

(3) Contract negotiations may create a healthy resident-administration relationship. The process of working out a mutually satisfactory contract can help housestaff and the hospital administration to understand one another's problems and needs.

Whether or not you feel it is to your advantage to have the type of contract outlined in the "Essentials of Accredited Residencies," you should be familiar with the "Essentials" and at least consider each of the issues mentioned in the contract guidelines. Many residents have been unpleasantly surprised to find themselves and their families inadequately insured or their working conditions unbearable. Residency is often a period during which effort above and beyond the

strict call of duty is necessary, but residents should have some basic employee benefits and be aware of what their rights and benefits are.

AMA-RPS Chairman-Elect Position Approved by AMA-RPS Assembly

The AMA-RPS Assembly passed a resolution at the July Annual Meeting calling for the creation of a chairman-elect. This position would be filled by election; the chairman-elect would serve on the RPS Governing Council for a period of six months or a year preceeding his or her assumption of the chairmanship. The consensus of the AMA-RPS Assembly was that establishing such a position would create more consistent, ongoing leadership in the RPS Governing Council. The proposal now must go to the AMA Council on Constitution and Bylaws for review. ◀

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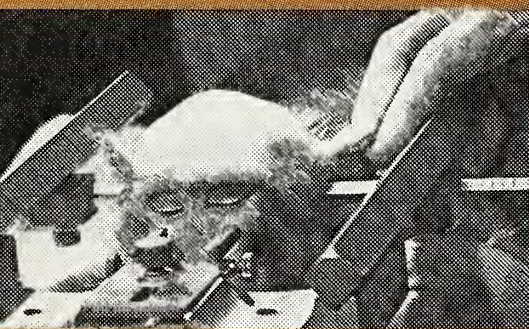
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A. Total No. copies printed (net press run)	15,704	15,500
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1. Sales through dealers and carriers, street vendors and counter sales	225	225
2. Mail subscriptions	14,412	14,494
C. Total paid circulation (sum of 10B1 and 10B2)	14,637	14,719
D. Free distribution by mail, carrier or other means, samples, complimentary, and other free copies	770	715
E. Total distribution (sum of C and D)	15,407	15,434
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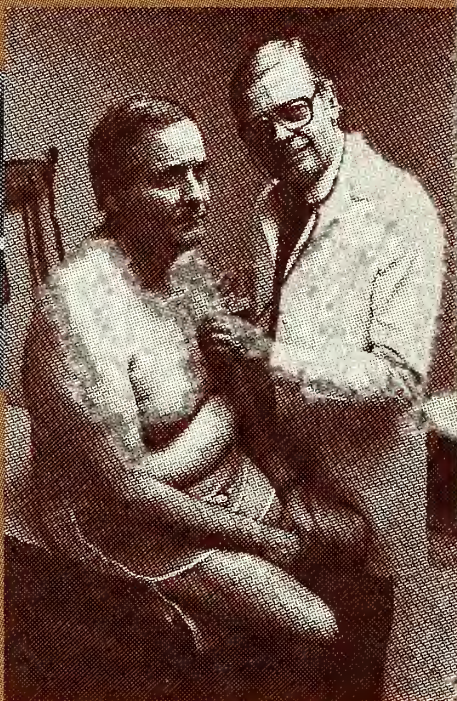
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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SBS In Action

(Continued from page 366)

against smoking on commercial aircraft¹⁸ and inappropriate distribution of infant formulae¹⁹ were referred to the Board of Trustees.

Reviewing the aforementioned actions, it is evident that the medical students now have a strong impact on AMA policy. Student membership presently represents the fastest growing segment of AMA members. The ISMS-SBS remains one of the most active and preeminent state medical association student groups. This impressive range of activity will continue with maintained student awareness of action by and issues facing organized medicine today. And with the continued support of the Illinois State Medical Society, the ISMS-SBS expects to play a major role at the Interim AMA-SBS meeting and will continue to keep the general ISMS membership informed of student initiatives via this column.

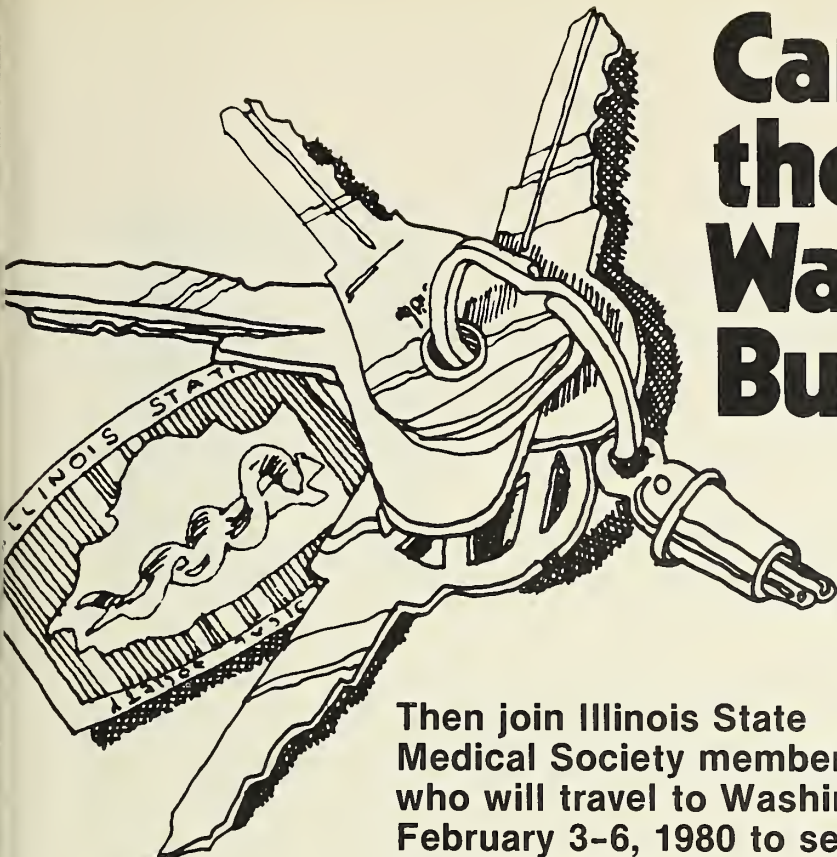
David H. Aizuss
Chairperson
ISMS-SBS
At-Large Officer
David J. Dries
Secretary/Editor

References*

1. Resolution 163
2. Council on Medical Education Report D
3. Council on Medical Education Report H
4. Resolution 132
5. Resolution 48
6. Resolution 164
7. Council on Constitution and Bylaws Report C.
8. Council on Constitution and Bylaws Report A.
9. Resolution 123
10. Council on Long Range Planning and Development Report A.
11. Board of Trustees Report G
12. Board of Trustees Report N and XX
13. Resolution 133
14. Resolution 161
15. Council on Scientific Affairs Report G
16. Resolution 160
17. Resolution 166
18. Resolution 162
19. Board of Trustees Report M.

*All taken from the 1979 Annual Meeting of AMA in Chicago

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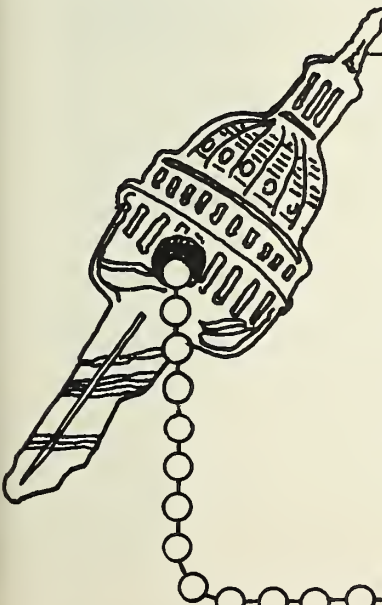
Discuss timely issues with the Illinois congressional delegation.

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Illinois Register
Illinois Department of Public Health
Text of Adopted Rules
Rules and Regulations for Clinical Laboratories and Blood Banks
Policy Statement No. 1
Advertising by Clinical Laboratories

The following is the text of Illinois Department of Public Health rules and regulations regarding advertising by clinical laboratories, as published in the Illinois Register. These regulations, filed on October 26, 1978, became effective November 5, 1978. This information is provided as a service to the membership.

The Department of Public Health has become aware of recent court decisions relating to commercial advertising by professional individuals and health care providers. Two decisions involving such advertising were rendered by the United States Supreme Court in the *Virginia Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.* 425 U.S. 748 (1976) and *Bates v. State Bar of Arizona* 97 S. Ct. 2691 (1977). The Court indicated in these cases that a total ban on advertising by professional individuals and health care providers could not be maintained in light of the First Amendment's protection of speech. However, traditionally unprotected speech such as false, fraudulent or deceptive and, in the health care field, misleading information could be prohibited and reasonable regulations imposed upon the advertisements of health care providers.

The Illinois Supreme Court in the *Department of Registration and Education v. Richard J. Talsky*, Docket No. 48997 (1977) indicated it would follow the criteria and rationale established in the above referenced U.S. Supreme Court decisions.

The Illinois Clinical Laboratory Act, Chapter 111 1/2, Paragraph 621-101 *et. seq.* of the Illinois Revised Statutes, contained two provisions, Section 8-101(c) and 9-101(c) of the Act, which prohibit commercial advertising to the public. The Department's Rules and Regulations for Clinical Laboratories restate the statutory provisions regarding advertising (Rule 9.10). However, until such time as legislation can be introduced to amend the Clinical Laboratory Act, the Department will follow the decisions of the Illinois and U.S. Supreme Courts. In furtherance of this, the Department has established the following policy:

The Department of Public Health, State of Illinois, will not take any action against a clinical laboratory for advertising to the public unless the advertisement is false, fraudulent, deceptive or misleading. In determining whether an advertisement is false, fraudulent, deceptive or misleading consideration shall be given to the interpretations of the Federal Trade Commission and the federal court decisions relating to Section 5(a) of the Federal Trade Commission Act.



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Itinerant Psychiatry

BY E. L. LOSCHEN, M.D./SPRINGFIELD

Rural communities present a variety of problems that create difficulty in the delivery of mental health services. Often psychiatry is represented in the person of an itinerant psychiatrist with no real ties to the community. There are certain approaches and success factors which may enhance the effectiveness of such an individual. However, the realities of distance, expense, and intermittent presence must be taken into consideration if the psychiatrist is to be effective.

Perhaps the most difficult problem in providing mental health services to rural communities is providing services of a psychiatrist.¹ This has led to the evolution of what might be called a model of itinerant psychiatry. The itinerant psychiatrist travels to these small communities, usually from an urban center, to provide a few hours per week or month of psychiatric care.² During the past five years, I have provided such services to various rural communities and have become aware of certain problems as well as success factors involved with itinerant psychiatry.

Because of the intermittent nature of such service, certain services cannot be delivered by the psychiatrist. Long-term, intensive psychotherapy or crisis intervention are services best handled by the permanent staff of these rural clinics. There is, however, a range of important psychiatric services that can be supplied on a limited basis. Consultation services to the mental

health clinic, the community hospital and local physicians can supply needed support to others providing mental health services.

Psychiatric evaluation, medication evaluation, and even aftercare services can be provided if adequate support from local physicians, and mental health professionals is available. In addition the psychiatrist can serve as a valuable resource for admission of patients to psychiatric facilities located outside the rural community. At times, the psychiatrist may be able to admit such patients to his own service in a hospital with which he is affiliated, therefore providing greater continuity of care for patients temporarily removed from their community.

There are several factors which, when present, enhance the effectiveness of the itinerant psychiatrist. The development of a strong working relationship with local rural physicians is most important, and is especially advantageous in providing care to chronic patients, patients requiring medication, or the occasionally difficult patient. The family physician is in the unique position of providing support, medication or psychotherapy to both the rural patient and his family. Developing such a relationship with the local physician requires that the itinerant psy-

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chiatrist pay particular attention to requests for assistance. Providing consultation on patients in the community hospital, or seeing patients in the mental health clinic for psychiatric evaluation are effective ways of introducing oneself to a local physician. Physicians will often provide long term follow-up on difficult patients if the psychiatrist is willing to see the patient occasionally and provide feedback on therapeutic progress. Conversely, local physicians will occasionally have patients with whom they cannot cope. Accepting referral of that patient usually will strengthen the working relationship with the local physician and result in better overall mental health care in the community.

Judicious use of the telephone also increases the effectiveness of psychiatric services to the rural community. Since direct services are often limited to a few hours per month, much of what happens to patients occurs when the psychiatrist is not personally available. Availability may be increased by utilization of the telephone in providing support to mental health clinic staff, local physicians and even patients and their families. Not uncommonly, a crisis may be resolved by simply responding to questions posed by the professional involved. When emergencies necessitating more intensive intervention do arise, treatment or even hospitalization can be initiated promptly by contacting the psychiatrist by phone, instead of trying to contain the crisis for several days or weeks until the psychiatrist's next scheduled visit to the community.

Although not necessary, it is helpful if the psychiatrist comes from a rural background.^{3,4} Rural cultural patterns are complex and can at times add baffling findings to otherwise clearly defined clinical syndromes. Rural families are often secretive about much that occurs in the home except, as one patient explained, "birth, death, and disaster." If the psychiatrist can recognize from his own background a rural patient's reluctance to reveal that several family members suffer from depression or other emotional problems, he may avoid unwarranted conclusions and inappropriate treatment recommendations. In addition, by recognizing the rural need for self-reliance,⁴ the psychiatrist will avoid treatment plans which would overly involve others in the community and therefore be unlikely to succeed.

Group work is often unsuccessful because of family secretiveness and the sharply drawn social class distinctions found in rural communities. Early during the formation of one rural mental

health clinic, an effort was made to establish a "Coffee and . . ." group for chronically ill patients. At first the patients refused to talk to each other or the aftercare worker and several patients dropped out of the treatment program. Drawing upon my own rural background, I suggested that conversation in the group be limited to non-threatening social issues. Individual sessions with the psychiatrist were moved to an adjacent room where privacy could be assured. In follow-up with these patients, they confirmed that differences in social class and the need to keep personal issues private "to not betray my family," were important factors inhibiting their previous participation. Over time, many in this group of chronic patients learned new social skills and recurrent hospitalizations were decreased. Developing the group process, however, required almost four years.

Personal Insight Helpful

Rural patients often also repress feelings, especially positive emotions, as a result of their cultural socialization. It is important for the psychiatrist to understand that no amount of encouragement in expressing affect is likely to succeed. The therapist from a rural background, however, may be better able to help such patients express emotions because of an awareness of the cultural limits of such behavior. For example, rural patients from agricultural communities may be able to verbalize feelings of affection, anger or disappointment if they are allowed to do so within a farmwork of weather, environment, or harvest outcomes. Starting there, the psychiatrist may be able to *slowly* shift such expression to more direct interpersonal issues which may be at the root of personal or family distress.

One must be careful, however, in attempting to characterize rural culture. Large differences exist between rural communities in one area of the United States and another area. Significant cultural differences may even exist between two adjacent communities, as the geography, type of economy, origins of settling pioneers, and accessibility to the outside world may vary. Cultural elements derived from these factors may significantly change the way people present themselves to the psychiatrist. A rural mining town is not the same as a rural farming town and neither are the people in them.

Staff in rural mental health clinics are often more stable in their length of employment than are their colleagues in large cities and usually develop a long-term relationship with the psy-

chiatrist. Obviously an advantage when the staff member is competent, this may be a significant disadvantage if the staff member's performance is problematic. Professionals are a scarce resource in the rural community,³ hence, if a mental health worker is inept or incompetent there is often no alternative available to the community. One possible solution is the hiring of professionals with lesser qualifications and then giving on-the-job training. This has been successful in several rural clinics and presents the opportunity for the psychiatrist to play a significant teaching role in the rural mental health center.

Although many difficulties of the itinerant psychiatrist may be overcome, some cannot, and certain accommodations must be made. Distance is not only costly to the clinic⁶ but troublesome to the psychiatrist. Often the psychiatrist must be paid for travel time and expenses from an already tight clinic budget.² For the psychiatrist, trips on narrow rural highways to clinics 50 or more miles away may be boring, stressful, and even dangerous in inclement weather. Further, the psychiatrist can never totally be accepted by the community because of the ephemeral nature of his or her presence. Events of local importance are often missed and relationships with the community leaders are, at best, exceedingly difficult to establish. Too often, the result is a retreat back to the psychiatrist's urban practice where life is often more orderly. However, this need not be so. What is needed is a sound commitment to the unique needs of the rural mental health center, a belief in its viability, and a firm understanding of limitations of itinerant psychiatry.

References

1. Jones, J.D., Wagenfeld, M.O., Robin, S.S.: "A Profile of the Rural Community Mental Health Center," *Community Mental Health Journal*, Vol. 12(2), 1976, pp. 176-181.
2. Allerton, W.S.: "Rural Mental Health in Virginia," *Virginia Medical Monthly*, Vol. 99, January, 1972, pp. 72-73.
3. Gertz, B., Meider, J., Pluckhan, M.L.: "A Survey of Rural Community Mental Health Needs and Resources," *Hospital & Community Psychiatry*, Vol. 26(12), December, 1975, pp. 816-819.
4. Berry, B., Davis, A.E.: "Community Mental Health Ideology: A Problematic Model for Rural Areas," *American Journal of Orthopsychiatry*, Vol. 48(4), October, 1978, pp. 673-679.
5. Masnik, R., Bucci, L., Isenberg, D., Normand W.: "Coffee and . . . : A Way to Treat the Untreatable," *American Journal of Psychiatry*, Vol. 128(2), August, 1971, pp. 164-167.
6. "Conference Report: Issues in the Delivery of Rural Mental Health Services," *Hospital & Community Psychiatry*, Vol. 28(9), September, 1977, pp. 673-676.

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Altered Coagulability in Malignancy

By JOSEPH A. CAPRINI, M.D., F.A.C.S./EVANSTON

The frequency and magnitude of blood changes in tumor patients are now well recognized and involve multiple diverse homeostasis systems including hemostatic and immunologic networks. The cancer victim may present with a variety of bleeding problems, thrombotic disorders, or show evidence of major organ dysfunction. A great deal of study has focused on mechanisms of metastasis including the role of anticoagulant therapy in inhibiting these processes. The primary purpose of this review is to construct a framework for understanding various paraneoplastic syndromes by an analysis of involved pathophysiologic mechanisms. Practical aspects of the data will be emphasized in order to outline patterns in clinical management of these varied disorders.

In 1865, Trousseau observed recurrent migratory thrombophlebitis, and subsequently many reports have appeared linking migratory thromboembolic patterns to those with cancer.¹⁻³ Pancreatic, gastric, ovarian, and pulmonary malignancies have frequently been associated with thrombotic disorders.⁴⁻⁷ Mucin producing adenocarcinomas have most commonly been associated with these disorders.⁸⁻¹³ Venous thrombosis, disseminated intravascular coagulation, or microangiopathic hemolytic anemia are but a few clinical variants seen in cancer victims.¹⁴ Indeed, these disorders may be the earliest clinical signs of a malignant process.^{15,16} Five to fifteen percent of patients with idiopathic thrombotic episodes are found to harbor a malignancy within one to two years.^{17-19,29} The recent introduction of invasive tests for deep venous thrombosis have shown a 33-50% postoperative incidence of thrombosis in those with malignancies.²¹⁻²³ Arterial thrombi

have also been observed in cancer, as well as numerous blood changes including thrombocytosis, elevated plasma clotting factors, shortened clotting time, accelerated thrombelastographic patterns, and fibrinolytic changes.²⁴⁻³⁵ A variety of clinical bleeding and thrombotic disorders have been associated with these changes. The term "hypercoagulable state" has been applied to test patterns showing shortened clotting times, elevated platelet and clotting factor levels, accelerated fibrinolytic activity, and altered thrombelastographic tracings. Unfortunately, these abnormalities are neither unique to cancer patients nor uniformly associated with clinical thrombosis or bleeding. Finally, the clotting system has been linked to metastatic tumor implantation and much experimental evidence has shown that coagulation mechanisms are involved in the spread of cancer. The involved mechanisms are incompletely understood and the clinical significance unknown at the present time.³⁶

Hemostasis

Hemostasis is the defense of the body against hemorrhage. Appropriate activation of these systems results when trauma occurs and intravascu-

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lar contents spill into the tissues triggering a complex series of reactions by contact activation. Unfortunately, violation of the intravascular space frequently occurs with activation of hemostasis inappropriately by substance producing contact activation. Sepsis, burns, and cancer are frequently responsible for the invasion of the blood stream. Table 1 illustrates some sources of activation in malignant conditions. The body cannot distinguish between these mechanisms of activation which may explain the varied clinical manifestations of deranged clotting systems in malignancy, *i.e.*, bleeding, thrombosis, etc.

The primary hemostatic components are the vessel wall, platelets, and plasma coagulation factors. Disruption of the vascular endothelium exposes blood to collagen fibers, and liberated vessel wall thromboplastins will trigger platelet aggregation and fibrin formation. Endothelial damage can result from activation of circulatory leucocytes and platelets by extravascular factors. Localized deposits of cancer cells on the vascular endothelium, or skip areas of endothelium due to rapid vascular proliferation within the tumor, can provide the nidus for platelet and fibrin deposition. The size of these deposits may produce local turbulence enhancing local hemostatic activation, particularly within the microcirculation. These changes often are reinforced by local vasoconstriction at the activation site.

The platelets occupy a dominant role in the regulation of hemostasis, liberating substances which, when activated, enhance vasoconstriction, catalyze coagulation factors with subsequent fibrin formation, and promote platelet adhesion and aggregation to form platelet plugs

The central process of hemostasis is the generation of thrombin. This process involves a number of sequential activation steps converting inactive prothrombin into thrombin, which then converts fibrinogen into fibrin monomers. These subunits spontaneously polymerize and interact with fibrin stabilizing factor to form a stable fibrin network. The final hemostasis plug is composed of platelet plugs, red and white cells entwined in a fibrin mesh.

The dissolution of this complex protein and cellular network is accomplished by fibrinolytic enzymes. Fibrinolysis is a fundamental defense mechanism to maintain vascular fluidity as well as a mechanism of tissue repair following injury. The delicate balance between clot formation and dissolution is maintained by hemostatic and fibrinolytic processes and can be altered in varying degrees in either direction by oncologic triggering

TABLE 1
INTRAVASCULAR TRIGGERING IN
MALIGNANCY

Tumor Toxins
Infection Around Tumor
Acidotic Cells
Necrotic Cells
Endothelial Skip Areas
Circulating Tumor Cells
Endothelial Damage

mechanisms (Table 1). As these processes are mediated through Hageman Factor (XII) following contact activation, certain immunologic systems are activated. Prior to the pioneering work of Ratnoff, these changes were always considered to be associated with antigen-antibody reactions.³⁷

Intravascular triggering of multiple systems, including platelet aggregation and adhesion, thrombin and fibrin formation can occur in tumor patients. If the changes are severe, depleted levels of blood elements with clinical bleeding may ensue. If low grade blood activation occurs, normal or elevated levels of platelets and fibrinogen can be seen depending upon the balance between production and destruction of involved factors. Clinical evidence of thromboembolism or varying degrees of organ insufficiency may be observed. When coagulation systems are activated, secondary triggering of fibrinolysis may result. If this process occurs, potent proteolytic enzymes circulate that digest clotting proteins, the fibrin plug, and other serum proteins. If the fibrinolytic process is extensive, serious depletion of clotting elements occurs, and combined with damaged fibrin produces a bleeding diathesis. The structural integrity and functional capacities of hemostatic proteins may be severely impaired along with inhibition of platelet function. The process may be self limited if plasma inhibitor levels are depleted or the underlying cause not removed.

This latter effect is the key ingredient to interrupt the vicious cycle of thrombosis and consumption that occasionally occurs. Simultaneously, the activation of Hageman factor and plasmin trigger the conversion of complement and kinin precursors to vasoactive peptides (Table 2). These elements cause vasodilation, bradycardia, increased vascular permeability, histamine and serotonin release, smooth muscle contraction, and local pain. If these effects are severe, circulatory collapse quickly appears and reduced flow stimulates further thrombosis, particularly within the

microcirculation. The resulting organ impairment with increased circulating toxic metabolic wastes is a potent trigger of further contact activation. The organism cannot survive long under these adverse circumstances. No single drug can block all of these systems; only total removal of the tumor will interrupt the continued intravascular contamination. In the majority of cases, all of these effects are mild, producing a mixed picture of thrombosis, bleeding, organ insufficiency, and circulatory impairment.

The value of laboratory investigation to assay the extent of these blood changes and uncover other nonrelated congenital or acquired deficiencies is obvious. A common problem is drug-induced platelet dysfunction secondary to aspirin, antihistamine, or other antiplatelet drug administration, particularly in the cancer patient. Dextran administration and renal impairment are additional important causes of depressed platelet function. Ten grains of aspirin can temporarily inhibit platelet adhesion, aggregation, catalysis of thrombin generation, local vasoconstriction, and heparin neutralization, which are all important platelet activities. These effects persist until new platelets are released into the circulation over a 4-7 day period, provided no further drugs are administered. The additional strain on hemostatic systems already weakened by the effects of tumor may produce a clinical picture of bleeding, thrombosis, organ failure, or circulatory collapse.

Surgical Intervention—Preoperative Considerations

The success of major operative procedures accompanied by additional tissue contamination of the circulation, blood loss, stress, and anesthesia, will be influenced by the nature and extent of existing changes. Platelet numbers may be reduced by chemotherapy, radiotherapy, or bone marrow tumor invasion. Surgical intervention must be preceded by documentation and therapy of major platelet disorders. Platelet population and morphology can be assessed by examination of the peripheral smear which will indicate the adequacy of platelet numbers and the presence of bizarre shaped or fragmented platelets which may indicate significant intravascular activation. If platelet numbers are decreased or increased direct platelet counting is indicated. Platelet function must also be measured to complete this phase of hematologic evaluation. The template Ivy bleeding time done on the forearm is a reliable measure and normally should be under seven minutes to exclude clinically significant platelet problems or vonWillebrand's disease. The inclu-

sion of this simple bedside test is a desirable and rewarding safeguard in minimizing the possible hazards of intraoperative or postoperative bleeding.

Platelet aggregation studies and platelet adhesive index measurements are sometimes necessary in the full evaluation of these problems. These tests do not replace the template bleeding time, which is the best clinical index of platelet function in patients undergoing an operative procedure. Clot retraction has not been particularly useful in the elucidation of these problems. We suggest that patients receiving anticoagulants have a bleeding time determination as part of the baseline hemostatic evaluation. The platelets are most important in neutralizing heparin and if they are not functioning normally due to drugs or another cause, or are reduced in numbers, serious bleeding following anticoagulant therapy may be anticipated. Postoperative prophylactic anticoagulants may cause hematoma which could lead to subsequent wound problems. This is particularly true in the case of cancer patients where wound healing may be impaired due to poor nutrition and other factors.

Therapy for platelet-related disorders is often difficult due to antigen-antibody reactions and short half-life that accompany transfusion of platelets. The most specific therapeutic modality is prevention, by avoiding or discontinuing any drugs which alter platelet function. In addition, renal functional abnormalities and liver problems could be corrected prior to operative intervention. Cases of bleeding of obscure cause may indicate vonWillebrand's disease or congenital platelet functional defects and should be thoroughly evaluated prior to operation. Surgical procedures in the face of thrombocytopenia should not be undertaken except as an emergency procedure and only with platelet packs available for transfusion intraoperatively. Platelet concentrates must be made by centrifuging and harvesting platelets from multiple fresh donor units. These platelets then need to be administered as quickly as possible following phlebotomy, without refrigeration, in order to retain some platelet function. These transfusions of platelets should only be used when absolutely necessary and while realizing that unless major HLA loci compatibility exists, platelet half-life is quite limited. Occasionally, a patient with a consumptive process may need small doses of heparin in conjunction with these transfusions to decrease the extent of consumption of clotting factors secondary to a tumor process and allow elevation of platelet numbers to the point

where surgery can be successfully accomplished. We feel that patients undergoing elective surgical procedures for malignant problems should never arrive in the operating room without a thorough evaluation of platelet structure and function. The minimal testing would include a peripheral smear and a template bleeding time. Any effects of possible drugs or other factors in reducing platelet structure and numbers must be evaluated preoperatively. Platelet related bleeding problems should be detected prior to surgery to avoid platelet transfusions intraoperatively.

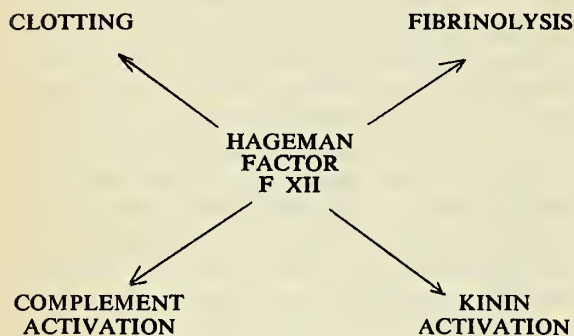
Although the processes of coagulation are rather complex and involve multiple factors which are incompletely characterized at the present time, testing in this area is rather precise. The principal test system to evaluate these problems consists of a properly done activated partial thromboplastin time. This measurement will evaluate the levels of all circulating clotting factors except one (Factor VII); this will indicate the integrity of the intrinsic thrombin generating pathway, the major one in maintaining the integrity of coagulation systems. The end result of these interactions is a conversion of fibrinogen to fibrin which forms the final stable hemostatic plug along with the platelet elements. It is most important to obtain blood for this test using a two syringe technique. Once the vein is punctured a core of tissue remains in the needle which must be cleared by flow of about 5cc of blood before a specimen for coagulation testing can be obtained. The venapuncture must be a clean one without undue trauma to the vessel wall. The specimen must be collected in polypropylene tubes with the proper amount of anticoagulant that is buffered to a neutral pH. The specimen must then be taken to the laboratory in ice and promptly spun to separate plasma from cells without delay. Once this has been accomplished, the specimen of plasma may remain on the bench in ice for several hours until the measurements are done. Strict adherence to these principles is necessary to avoid artifacts that greatly weaken the value of the partial thromboplastin time. Excessively long values or very short ones are two common manifestations of errors in technique which must be avoided. If this procedure is carefully done, a comprehensive evaluation of the coagulation system is possible. Occasionally, in the tumor patient, it will be desirable to measure fibrin split product levels. The same details of blood procurement must be followed. It is important to monitor this index of fibrinolytic activity since often it will serve as an

indication of the clinical course of the patient regarding postoperative bleeding and coagulation problems. Excessive fibrinolytic activity preoperatively may indicate a variety of problems in the tumor patient, including distant metastases, extensive liver involvement, or active toxin production from tumor producing increased intravascular coagulation and fibrinolytic activity. It is important to preoperatively evaluate these systems, since excessive fibrin split product activity may produce serious intraoperative bleeding that may be difficult to overcome. Such patients often have coexistent defective platelet function and structure problems and a combination of these difficulties intraoperatively, along with extensive blood loss due to a large surgical procedure, may produce a fatal outcome, even though total extirpation of a malignant process is accomplished by the surgeon. A frequently overlooked problem in the tumor patient, particularly where preoperative or intraoperative antibiotics are required, is vitamin K deficiency. This vitamin cannot be stored by the body and constantly must be supplied by the diet or parenterally. Antibiotics reduce the intestinal flora, which is required for absorption of this vitamin as well as its conversion into the vitamin K dependent coagulation factors. An intact liver is required for this conversion and particular attention must be devoted to this problem in cases with malignancy involving the biliary tract. A depressed level of these clotting factors may produce serious bleeding that is difficult to differentiate from a consumptive process, particularly postoperatively. Parenteral vitamin K should be available and the levels of coagulation factors checked against preoperative values in order to avoid serious bleeding difficulties. Often the tumor patient will require anticoagulants and the administration of these powerful drugs in a patient with a vitamin K deficiency can produce serious hemorrhage. Radical oncologic surgical procedures requiring five units of blood or more can produce a loss coagulopathy in which clotting factor levels are depleted intraoperatively. Surgeons should be aware of all of these problems and make appropriate preoperative preparation in order to minimize the chance of intraoperative hemorrhage.

Use of Plasma

Unlike platelet disorders where therapy is difficult and cumbersome, the treatment of all coagulation factor deficiencies can be readily accomplished by the administration of fresh frozen plasma. This is an extremely valuable blood prod-

TABLE 2
INTRAVASCULAR CONTAMINATION



uct obtained by centrifugation of freshly drawn blood with separation of the cells, and freezing of the plasma at -45° Centigrade. The resultant product is stable in the blood bank for two years and contains good levels of all clotting factors. Disadvantages of the use of this product are the thirty minute time delay required for thawing to be completed; and, in patients with circulatory overload, the administration of large volumes of plasma may represent additional stress on the cardiovascular system. Fresh frozen plasma is the specific treatment agent for intraoperative use when bleeding occurs that is not specifically attributed to a technical defect. One unit of fresh frozen plasma should be administered for every five units of shed blood during an extensive surgical procedure. This will minimize the risk of loss coagulopathy. We have not observed any difficulties with the prophylactic administration of this product, and an additional benefit is expansion of the plasma volume. Administration of this product will correct vitamin K deficient states as well as deficiencies of all coagulation factors, regardless of etiology. Failure of fresh frozen plasma to correct the bleeding may indicate the presence of a coexistent platelet problem, excessive fibrinolysis producing circulating anticoagulant-like activity, or an endogenous circulating anticoagulant that occasionally occurs in the course of difficult illnesses. A common example of this latter category is systemic lupus erythematosus.

General Considerations

The approach to problems involving the coagulation systems should include a thorough

preoperative evaluation, looking for specific defects that are correctable, including vitamin K deficiency. The activated partial thromboplastin time and fibrin split products levels should be obtained in all cases before large operative procedures for malignancy. The prophylactic intraoperative and postoperative administration of fresh frozen plasma is a useful adjunct in providing a level of hemostasis that is most comprehensive. One should avoid the administration of lyophilized fibrinogen or factor concentrates that carry an inordinately high risk of hepatitis. The availability of fresh frozen plasma obviates the need for these other products.

Accelerated fibrinolysis is commonly observed in cancer patients. This process is usually the result of intravascular coagulation secondary to intravascular contamination with fibrinolytics. Some of these mechanisms are depicted in Table 1. The keystone of therapy in this area is eradication of the tumor by all available means. It is possible to temporarily decrease the level of bleeding in these patients when severe coagulation activation occurs by the administration of heparin. Often heparin must be combined with plasma and platelet transfusions until the underlying process has been controlled by surgery, irradiation, chemotherapy, immunotherapy, or a combination of these. Specific antagonists of fibrinolysis should be used rarely. Occasionally exaggerated fibrinolysis will produce clinical bleeding. Combination therapy to block coagulation and fibrinolysis, using anticoagulants and antifibrinolytic agents along with rigorous replacement therapy, is occasionally required. One must be aware that these treatment agents are only effective temporarily in controlling clinical bleeding problems. An additional benefit may include inhibition of microvascular thrombosis that is often coexistingly present in these seriously ill patients. Unless the underlying process can be controlled, however, ultimate success of all of these adjunct measures will not be possible. The inability to block complement and kinin activation effectively with currently available treatment agents greatly limits our efforts to protect the body against excessive intravascular contamination in malignancy. The fact that heparin or amicar, although controlling bleeding, may not reverse the outcome of a seriously ill patient, may reflect the inability to block associated immunologic changes that are present in these patients. Advances in this area must await the development of specific antagonists to all components affected by contact activation secondary to tumor (Table 2).

Thromboembolism

Closely associated with clinical bleeding problems related to multiple systems activation are problems associated with venous thrombosis and pulmonary embolization. The frequency of these disorders has recently been established with a high degree of accuracy because of the introduction of ^{125}I labelled fibrinogen and pulmonary photoscanning.^{38,39} Thousands of patients have undergone these procedures and correlation with invasive testing by venography and pulmonary angiography has established the value of these radioisotope measurements in delineating thrombotic disorders. Previously, clinical evaluation of thromboembolic problems left much to be desired. The recent developments, including these new tests, have indicated the inaccuracy of clinical evaluation. The majority of postoperative thrombi, for example, are not accompanied by clinical symptoms unless pulmonary embolization occurs. A recent review estimates that the frequency of deep vein thrombosis in the legs is 16% to 42% postoperatively.⁴⁰ Cancer patients are among those with the greatest risk following surgical procedures. The etiology of these changes is not completely understood. However, a variety of mechanisms undoubtedly contributes to the thromboembolic states encountered in the postoperative period in these individuals. In addition to the major thrombotic processes, microvascular thrombosis in the vital organs can also occur. This may produce a clinical picture of renal, hepatic, cerebral, or pulmonary impairment that may be mild, moderate or severe. The extent and severity of these changes are related to multiple factors that can be traced to the effects of the tumor upon the organism. The appearance of these clinical derangements should indicate the existence of significant changes in the hemostatic mechanisms that then should be documented and treated by all appropriate measures, including on occasion, anticoagulants. There is now little doubt that the prophylactic administration of small doses of heparin pre- and postoperatively does significantly reduce the incidence of postoperative thromboembolism in general.⁴¹ Recently, enthusiasm for this approach has been dampened by the reports of significant postoperative bleeding that have appeared.⁴² Postoperative hematoma in the wound can represent a serious problem since infection and eventual wound separation often result. This may require additional surgical procedures that may not be well tolerated by the patient. In addition, intro-abdominal hematomas

can result in abscess formation that may be troublesome or even disastrous, particularly following major tumor extirpation in seriously ill, nutritionally depleted individuals. Rarely, local reactions may occur following minidose heparin injections, which may necessitate further treatment.⁴³ The advantages and disadvantages of prophylactic anticoagulation must be individually weighed in oncologic patients preoperatively. Strict attention to the diagnosis and treatment of existing bleeding problems is absolutely mandatory in these individuals. The current body of evidence regarding postoperative thromboembolic problems, however, suggests that patients not protected by anticoagulants are at significant risk, particularly following major tumor surgery. Fortunately, alternatives exist, including the recently reported monitoring trials which have been very successful in orthopedic patients following total hip replacement.⁴⁴ This approach consists of preoperative injection of radiolabelled fibrinogen plus impedance testing. Both tests are noninvasive and can be continued throughout the postoperative period. If abnormalities develop in both these tests, venography is done and patients with actual significant clots in the popliteal fossa or higher are treated with heparin anticoagulation. In this way, patients who do not have actual thrombosis that is significant and life threatening do not receive the anticoagulants, while those who do have potentially dangerous lesions are treated fully with standard techniques. The cost of this program is rather high in terms of testing in these patients; however, it is much lower than the cost of delayed hospitalization for bleeding complications incurred following anticoagulant therapy. We would strongly recommend that patients undergoing major oncologic surgical procedures have attention directed toward the problem of venous thromboembolic disorders. Minidose heparin is very effective in general surgical and gynecologic operations, although where a risk of bleeding might jeopardize the patient's course, then the monitoring protocol should be used. Certainly all individuals with pre-existing bleeding tendencies should be considered for the monitoring protocol, as well as those involving high risk intrathoracic and intracranial operative procedures. In the light of current knowledge regarding hemostatic mechanisms and thromboembolic problems, it would seem appropriate to obtain preoperative coagulation profiles as well as to make definite plans to minimize the occurrence of postoperative thromboembolic disorders.

Anticoagulants And Cancer

The long association between disorders of bleeding and thrombosis in patients with malignancy quite naturally led to investigation of the influence of anticoagulants upon growth and development of metastatic deposits. The first reports by Terranova, *et al.*, indicating that anticoagulants would decrease metastases after intravascular injection of tumor cells led to further work, most notably that of Wood, using the rabbit ear chamber with cinemicrophotography describing in detail the formation of blood borne metastases and its association with coagulation.^{45,46} Others demonstrated that fibrin was associated with tumor invasion in humans followed by organization and growth of new blood vessels, providing cancer with its own stroma.^{47,48} Human tumors were also found to be rich in thromboplastic activity. Coumadin was found to be more effective than heparin in preventing the precipitation of fibrinogen on cancer cells and the formation of fibrin.⁴⁹ Since these early reports a number of studies have been undertaken in order to further test these postulates and perhaps provide additional adjunct therapy in patients with malignant disease.⁵⁰⁻⁵² Currently, a multicenter trial is under way to evaluate the efficacy of anticoagulant therapy by the oral route as an adjunct measure in patients with metastatic disease. To date, unfortunately, no clearcut superiority of these agents has been demonstrated that is significantly convincing to recommend this therapy on a widespread basis. If one reflects momentarily on the concepts of intravascular clotting with Hageman factor activation and resultant multiple systems activations, one may understand why these experiments have been on the one hand so tantalizing, and on the other so disappointing. The multiple systems activation that follows the introduction of contaminant material in the bloodstream as commonly occurs with malignant disease, causes the activation of not only coagulation and fibrinolytic systems but also immunologic systems. Anticoagulants are specific antagonists of the coagulation schema including inhibition of platelets. Unfortunately, these agents do not affect fibrinolytic activity except indirectly by decreasing the amount of thrombosis in the system. They have no effect upon the multiple immunologic systems that are activated in these problems, and herein lies the greatest pitfall in advocating simply single agent anticoagulant blockage for the broad range of activated systems. It is apparent that in the future, multiple treatment protocols must be de-

signed that effectively block coagulation, fibrinolysis, and the immunologic changes that are occurring. Furthermore, it is not known whether blocking of all these systems may lead to an improved success with inhibition of the malignant process at the present time. Investigations by our group following major thermal injury have indicated a prognostic value following measurement of specific components of hemostatic and immunologic systems. It is possible that the burn situation can be extrapolated to the neoplastic setting since multiple system activations would seem to be a common denominator.^{53,54}

Summary

It is remarkable how advances of the past decade have contributed significant new information to the problem first observed by Trousseau over 100 years ago when recording the association between thrombosis and malignancy. At the present time a number of advances have been made which can be utilized by those involved with the care of tumor patients to improve the approach to the difficult situations. The importance of adequate preoperative testing to evaluate the competence of the hemostatic pathways has emphasized that this surveillance should be extended to all patients with malignant disorders, particularly those undergoing chemotherapy. Attention to correction of significant defects before the institution of surgical or chemical therapy is vital to improve results with these patients. Considerations must be given to antithrombotic surveillance or prophylaxis in all of those individuals subject to major operative procedures or periods of bed rest for treatment by other modalities. A variety of newer tests are now available in order to greatly facilitate the pursuit of these goals. The importance of intravascular clotting and fibrinolysis with immunologic systems activation has been described and seems to form a broad pathophysiologic base to explain some of the altered blood changes in malignancy. The use of anticoagulants to inhibit metastasis is an offshoot of these pathophysiologic developments. Looking to the future, it would appear that the hemostatic and immunologic blood systems will become increasingly important in both the diagnosis and management of malignant processes. ◀

References

A complete set of references for "Altered Coagulability in Malignancy," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

Electrocardiographic Changes in Multiple Sclerosis

BY S. B. VITTAL, M.D., T. N. BABU, M.D., S. KAPLITZ, M.D. AND
A. A. LUISADA, M.D./OAK FOREST

A retrospective electrocardiographic study was made in 208 patients with multiple sclerosis. The frequency of abnormalities in the various age groups was compared with that found in 341 other patients treated in the same hospital. A statistical comparison was made.

The most common and constant abnormality was sinus tachycardia, followed by ventricular ectopic beats. Incomplete right bundle branch block, left anterior or posterior hemiblock, nonspecific ST-T wave changes and low voltage were all found more commonly than in controls.

The possible causes of the changes are discussed.

Several muscular and neurological diseases have been studied by means of the electrocardiograph and this tracing has revealed cardiac abnormalities that had not been suspected by means of physical examination. Multiple sclerosis (MS)

had not been investigated from an electrocardiographic point of view. For this reason, we undertook a retrospective study of all electrocardiographic tracings of patients with multiple sclerosis treated in our hospital, and compared them with those of other patients of the same age, considered as "controls."



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Material and Method

A total of 208 inpatients with multiple sclerosis had been treated in our hospital for periods extending from 3 to 21 years. Several tracings (a minimum of one per year) were recorded in each case and the series for each patient was studied. A correlation with the stage of the disease was not possible, due to difficulty in determining time of disease onset. The patients received no drug that might have affected heart rate, and in particular, no cardiac drug. The abnormalities that are reported are those consistently found in their tracings, year after year.

As controls, we studied the electrocardiograms of 341 inpatients in the same age groups that were treated in our hospital for long periods of time and for the most varied conditions.

Their age distribution was as follows:

1. Age 15-40—46 cases of MS; 46 controls.
2. Age 41-60—116 cases of MS; 126 controls.
3. Above 60—46 cases of MS;* 169 controls.

A further study was made on the possibility that sinus tachycardia might be related to the presence of a Foley catheter. Fifty patients, not having MS, were selected at random (25 males and 25 females) and their heart rates were recorded. Only four of them had a heart rate over 100 and this tachycardia was generally of only a few days duration (caused by a urinary infec-

**In this group, 43 patients were between 60 and 70 while only 3 were older.*

Table 1
Percentage Of Electrocardiographic Abnormalities In Multiple Sclerosis

E.C.G. Abnormalities	15-40 Years			41-60 Years			Above 60		
	M.S.	C	chi ² T	M.S.	C	chi ² T	M.S.	C	chi ² T
Sinus Tachycardia	41	none	P<.001	37	0.7	P<.001	13	0.6	P<.001
Sinus Bradycardia	2	none	P<.05	1.7	none	P<.05	2	1.2	NS
Supra-ventricular E.B.	none	none	—	1.7	none	NS	4.3	4.7	NS
Ventricular Ectopic Beats	none	none	—	6	0.7	P<.01	17	4	P<.01
Atrial fibrillation	none	none	—	none	0.7	NS	2.3	7	NS
Grade I AV Block	none	6.5	NS	none	7	NS	6.5	2C	NS
Intra-ventricular C.D.	none	none	—	1.7	none	NS	none	0.6	NS
Incomplete R.B.B.B.	8.7	none	P<.02	5.2	0.7	P<.02	8.7	none	P<.001
Complete R.B.B.B.	none	2.1	NS	2.6	none	NS	2	4.1	NS
Left Anterior Hemiblock	6.5	none	P<.05	12	none	P<.001	15	2.9	P<.001
Left Posterior Hemiblock	8.7	none	P<.05	3.4	0.7	NS	none	none	NS
Complete L.B.B.B.	none	none	—	1.7	none	NS	2	4.7	NS
Myocardial Infarction	2	4.3	NS	20.7	21.3	NS	36.5	35.9	NS
Nonspecific ST & T	15.2	none	P<.01	23.9	none	P<.001	9.2	1.2	P<.01
Low Voltage	2	none	P<.05	12.9	0.4	P<.001	15	none	P<.001
Left Ventricular Hypertrophy	6.5	13	NS	6	2.4	NS	4.3	6.5	NS
Right Ventricular Hypertrophy	none	none	NS	4.3	none	P<.01	none	none	NS
Total No. Abnormal ECG per cent	69.6	26		83.6	30.2		89.1	66.	

Chi²T = chi square test
NS = non significant
MS = multiple sclerosis
C = controls

tion). Moreover, only a minority of the cases of MS had a Foley catheter.

The diagnosis of MS had been previously made in other hospitals before admission. It was confirmed in our neurology department, where treatment of the patients was continued for many years and typical signs of MS, including optic atrophy, were noted.

Following study of the 12 lead electrocardiograms, abnormalities were tabulated and compared to those found in "control" subjects. Percentages of the abnormalities between the two groups for each age range were statistically studied by using the chi square test described by Randall.¹ This test was made using the Yates correction for small samples when appropriate and revealed whether the different incidence of abnormalities between the two groups was significant or not.

The description of the ECG changes was consistent with current criteria and does not require a detailed explanation.

Results

The most significant changes found in multiple

sclerosis (Table 1) were the following.

Sinus tachycardia: There was significant difference between patients with MS and controls at all ages. When tachycardia was present, the range was from 100 to 140/min. (Average 119). As a correlation, sinus bradycardia was found less often in MS, at least below 60 years.

Ventricular ectopic beats: They were more frequent in MS than in controls but the difference was significant only in patients above 40 years of age. The ectopic beats were unifocal and occasional, i.e., every 10-15 beats.

Incomplete right bundle branch block: This was more frequent than in controls in all three age groups, and the difference was statistically significant. However, the percentages were not very high. The same was true for the following changes.

Left anterior or posterior hemiblock: At all ages with fairly high percentages.

Nonspecific ST-T changes, as well as low voltage: Found more frequently in MS than in controls with significant difference in all three age groups.

Discussion

Cardiac involvement in multiple sclerosis has not been considered up to now, as demonstrated by the absence of any publication. Even textbooks on this disease fail to discuss the autopsy findings regarding the heart,² with the exception of Lumsden,³ who found no cases of heart disease in 60 consecutive cases of multiple sclerosis.

Our electrocardiographic findings in multiple sclerosis are not impressive. Still, they reveal the frequent occurrence of certain changes, which are statistically greater than in control subjects of the same age and are not caused by treatment modalities.

Sinus tachycardia is the most outstanding abnormality, as it reaches 41% between 15 and 40 years, 37% between 41 and 60 years, and 13% above 60 years. A possible explanation is a central stimulation of the sympathetic system that is manifest even at rest and is not caused by possible concomitant processes, like Foley catheter irritation or secondary infection. Possibly correlated with this sympathetic stimulation are the ventricular ectopic beats, which were present in 17% of patients over 60 in comparison with 4% of the controls. One possibility that should be considered is that the tachycardia is a secondary effect of the hypotension, an abnormality that seems to be the rule in these patients.

The other observed changes may be grouped together: incomplete right bundle branch block, left anterior or posterior hemiblock, low voltage, and nonspecific ST and T wave changes. The first three may be due to a process of fibrosis that develops either in certain bundles or as a diffuse process. The last may be the result of electrolyte changes. Taken together, they give the impression that some progressive alteration of the myocardium takes place in multiple sclerosis. Should either a viral or an immune process be recognized as the cause of the disease, a cardiac involvement would not be surprising.

It is interesting to note that, contrary to the above alterations, complete bundle branch block (either right or left) is not more common than among controls, and myocardial infarct occurs with the same frequency as in controls, thus excluding a greater involvement of the coronary arteries in multiple sclerosis. ◀

References

1. Randall, J.E.: *ELEMENTS OF BIOPHYSICS*. Chicago Year Book Publ., 1958 (123).
2. Woltman, H.W., Merritt, H.H., Wortis, S.B., and Hara, C.C.: *MULTIPLE SCLEROSIS AND DEMYELATING DISEASES*, Vol XXVIII, Res. Public., Assoc. for Res. in Nerv. and Ment. Dis., Williams and Wilkins, Baltimore, 1950.
3. Lumsden, C.E. In *HANDBOOK OF CLINICAL NEUROLOGY* V. 9 (Editor Vinken), 1971 Amer. Elsevier, Publ.

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Bilateral Pneumothorax and Pneumopericardium Followed by Pericardial Effusion

JOHN A. DAMERGIS, M.D., and ROBERT P. GORDON, JR., M.D./ELMHURST

A rare occurrence of non-penetrating traumatic pneumopericardium with bilateral pneumothorax followed by pericarditis and pericardial effusion is presented. Bilateral pneumothorax should alert the physician to the possibility of a concurrent pneumopericardium. This myocardial contusion may subsequently manifest itself as pericarditis and pericardial effusion.

Pneumopericardium is an uncommon condition, especially if traumatic nonpenetrating injury is a cause. The purpose of this report is to present a case of traumatic pneumopericardium, associated with bilateral pneumothorax, which was followed by pericardial effusion.

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ROBERT P. GORDON, JR., M.D., was the senior attending physician in the department of surgery at the Elmhurst Clinic in Elmhurst at this writing. Dr. Gordon is now deceased.

Case Report

A 16-year-old white male was admitted to the hospital after an automobile accident in which he was a front-seat passenger. The initial physical examination disclosed wide-spread musculoskeletal tenderness. Bone X-rays failed to reveal any fracture. The admission portable chest X-ray showed a small pneumothorax on the right side, plus a mildly elevated left diaphragm. A repeat X-ray that same day showed a bilateral pneumothorax to have developed along with axillary and cervical subcutaneous emphysema. Bilateral chest tubes were then placed with satisfactory results. By the twelfth post-trauma day, chest X-ray disclosed a residual pneumothorax

and a pneumopericardium. (Figure 1)

On the eighteenth post-trauma day, the patient complained for the first time of a dull non-radiating, substernal chest pain, associated with intermittent pleuritic pain and an oral temperature of 100°F. Physical examination then disclosed a definite pericardial friction rub. Chest X-ray now showed an increased cardiothoracic ratio, as well as obliteration of the pneumopericardium, (Figure 2) presumably by pericardial effusion which was demonstrated to be present on echocardiography. ST-T changes on electrocardiography were noted to be compatible with pericarditis. The patient showed no signs of vascular embarrassment. After three days of

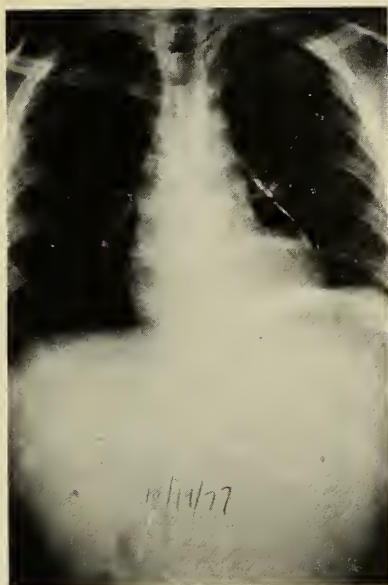


Figure 1
Posterior-anterior chest X-ray showing small left pneumothorax, pneumopericardium and elevation of the left hemidiaphragm.

corticosteroid therapy, the patient became asymptomatic, and the cardiac configuration normalized on chest X-ray. The patient was discharged from the hospital some 26 days post-trauma on a regimen of progressive tapering of the corticosteroid dosage.

The patient was seen in the office one month after discharge from the hospital; he was asymptomatic, taking no medication, and continued to have a normal chest X-ray.

Discussion

Pneumopericardium is a rare condition. Non-penetrating chest trauma as a cause is rare among those outlined by Shackelford.¹ Four groups are described. (1) Patients demonstrating blunt chest trauma with no opening in the pericardium; (2) Individuals where the pericardium is perforated from without; (3) Cases where a purulent pericarditis exists causing rupture outward into an air-containing organ and (4) Cases where it is not

known if a perforation exists.

Appropriate cases have been described showing pneumopericardium consequent to blunt chest trauma, penetrating trauma, esophageal perforation and positive pressure mechanical ventilation.¹⁻⁴

Presumably in our patient, alveolar rupture from the trauma caused air to escape and dissect through the interstitial lung tissues to the hilum, mediastinum, neck, and pericardial sac.⁵ As was the case with our patient, traumatic, non-penetrating pneumopericardium in itself generally should cause no concern for tamponade and can be treated conservatively. The superimposition of pericardial effusion, however, should alert one to the possibility of tamponade. Our patient, on successive echocardiograms, had documented resolution of his effusion, coincident with corticosteroid therapy. Signs of pneumothorax and subcutaneous emphysema pose a strong argument to bronchoscope such patients in search of tracheobronchial

rupture.⁶ However, a bilateral pneumothorax, if due to tracheobronchial rupture, would be central in origin. The most common site of rupture would be at the carina, associated with hemoptysis, cough and severe respiratory distress. Since this patient appeared clinically well and stable, it was felt the origin of his air leak was bilateral alveolar rupture with dissection. Additionally, our patient demonstrated a traumatic pericarditis with pericardial effusion obliterating the previous pneumopericardium. Occurring some two and one-half weeks after trauma, this timing is consistent with that seen in general category of pleuropericarditis secondary to cardiac injury. Conservative treatment consisting of corticosteroid therapy and careful observation eventually led to the complete resolution of this sequence. ◀

Acknowledgements

The authors thank Beverly Caruso and Dennis McDowell, medical photographer, for their assistance with the preparation of the manuscript.

References

1. Shackelford, R.T.: "Hydropneumopericardium. Report of a Case with Summary of the Literature," *JAMA* 96:187-192, 1931.
2. Cargill, A.O., Galasko, C.S.B. and Gunning, A.J.: "Pneumopericardium Following Closed Chest Injury: Report of Two Cases," *Injury* 4:221-224, 1973.
3. Curry, N., and Anderson, R.S.: "Pneumopericardium and Esophagopericardiac Fistula following Chronic Esophagitis Presenting as Acute Respiratory Distress," *Chest* 66:731-733, 1974.
4. Loftus, J.W., Susen, A.F., March, J.H., et al.: "Pneumopericardium in Infancy," *Am J. Dis Child.*, 103:93-94, 1962.
5. Rosen, A., Vaudagna, J., and Jamplis, R.W.: "Spontaneous Pneumopericardium," *Am. Rev. Resp. Dis.* 87:764-765, 1963.
6. Bertelsen, S., and Howitz, P.: "Injuries of the Trachea and Bronchi," *Thorax* 27:188-194, 1972.

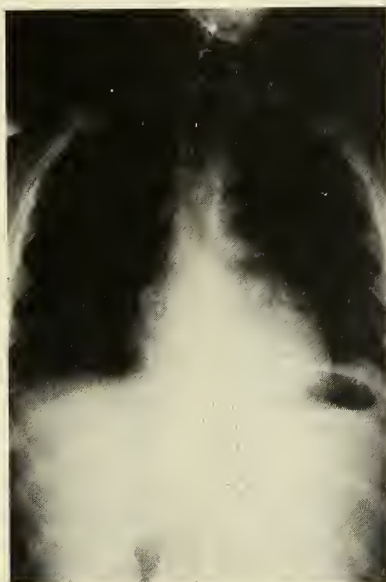


Figure 2
Posterior-anterior chest X-ray demonstrating resolution of the pneumothorax and disappearance of the previous pneumopericardium, associated with an increased cardiothoracic ratio.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 23, 1979

Case Report

Colon Ischemia After Aortic Aneurysm Resection

Dr. Renee Hartz: A 72-year-old man presented to the emergency room of the Northwestern Memorial Hospital. The evening of admission he had gone to a restaurant and after consuming four martinis before dinner, collapsed. When the patient became more alert, he gave a history of severe back pain for several days prior to this episode. He appeared to be an alert, oriented, elderly white man. Blood pressure was 100/60 recumbent, and 90/60 erect. The patient was restless, and complained of severe back pain. Physical examination revealed markedly distended abdomen and a tender, pulsatile lower abdominal mass. His peripheral pulses were normal and his cardiac exam was unremarkable except for tachycardia.

He was taken to the operating room, receiving fluid resuscitation en route. An exploratory laparotomy was performed for a ruptured abdominal aneurysm. He had a large aneurysm that had ruptured on the left side and produced a massive retroperitoneal hematoma. He had bilateral iliac artery aneurysms as well. Of note,

the inferior mesenteric artery did not bleed when transected. An aortobifemoral bypass graft was performed. The patient received multiple transfusions but was stable at termination of the procedure.

In the intensive care unit, he required prolonged ventilatory support for pre-existing pulmonary disease. The patient remained distended, and had adynamic ileus for approximately five days. His abdomen was soft and non tender, and, on the sixth postoperative day he had a small stool. On the seventh and eighth postoperative days he began to have small, loose stools that were not bloody, although two stools were guaiac positive. Through this period of time, his white blood count varied from 12-14,000.

On the ninth postoperative day his course changed dramatically. He became acutely ill and hypotensive. He complained of severe diffuse abdominal pain. On physical exam, he was more distended and was diffusely tender, most markedly in the left lower quadrant. His white blood count was 14,000 with a shift to the left. His hematocrit was 36. Plain abdominal films were

consistent with the small bowel obstruction. The patient was returned to the surgical intensive care unit where intravenous fluid was administered. He was taken to the operating room with a diagnosis of strangulated bowel obstruction. At laparotomy, gross fecal peritonitis was found, and the entire sigmoid colon was necrotic. The necrotic bowel was resected and a colostomy was established in the transverse colon.

Dr. Luis Queral: My discussion concerns the etiology of colon ischemia. Colon ischemia after aortic surgery is an unusual event. In the largest series in the literature, about half of those patients with postoperative colon ischemia, had surgery for aortic abdominal aneurysms and the other half for portotiliac obstructive disease or for the Leriche Syndrome. In this series, the incidence of colon ischemia was 2.1% in the group with surgery for aortic abdominal aneurysm, but nil among patients operated for the Leriche Syndrome. Thus, colon ischemia usually occurs after surgery for aortic abdominal aneurysm. In other words, if a patient has developed collateral pathways, as he normally would with aortoiliac occlusive disease, the chances of having colonic ischemia is markedly decreased.

Colonic Vascular Anatomy

I think that this point can be better understood if the vascular anatomy of the colon is closely examined. Most patients' main blood supply to the left colon is from the inferior mesenteric artery. The significant collateral is the marginal artery which communicates with the superior mesenteric artery, inferior mesenteric artery and the middle hemorrhoids, which are branches of the internal iliac system. Most patients with abdominal aortic aneurysms have thrombosis of the inferior mesenteric artery and collateral circulation is usually sufficient to prevent colonic ischemia after dissection. Collaterals have been known to arise from the lumbar, contralateral iliac and celiac trunk vessels, but this only occurs if the obstruction of blood supply is gradual. Significant vascular anatomical variance presents further complications. These marginal vessels are not present in approximately 5% of the patients, and approximately 20% of the patients have an abnormal variance of the marginal arteries. Thus, there is at least one critical factor in the pathogenesis of this disease, the vascular anatomy of the colon. The operative procedure can interfere with the vascular blood supply and postoperative patient management can also contribute to colon ischemia. When

TABLE 1

1. Gastrointestinal Bleeding
 - a. Acute arterial bleed (in left gastric artery, gastroduodenal artery)
 - b. Transhepatic portal vein catheterization with obliteration of varices.
2. Neoplasm
 - a. Pre-operative. To decrease vascularity of neoplasm.
 - b. Symptomatic. To control bleeding (i.e. intractable vaginal gastrointestinal or urinary bleeding).
 - c. Definitive. Non-operable candidate.
3. A-V malformation

the inferior mesenteric artery is patent (when it is the main blood supply to the descending and sigmoid colon) the patient can still have severe ischemia of the colon after surgery.

Proper Ligation

I want to emphasize that the inferior mesenteric artery should be ligated flush with the aorta. If one wanders distally in a surgical dissection, it is quite easy to ligate the marginal artery, thereby interfering with the lateral collaterals. The internal iliacs or hypogastrics should be perfused after reconstruction to insure blood supply to the left colon. We can make a limited assessment of ischemia in the operating room by noting obvious things such as color, peristalsis, and marginal vessel pulsations. But this is not foolproof, insofar as you can have ischemia of the colon and never notice it. As you know, the mucosa is most susceptible to ischemia and the bowel's serosa can be perfectly normal in appearance while significant ischemia is present. In this patient, the sigmoid colon by external appearance was totally normal at this time of operation.

Cyanotic Sigmoid Colon

What should one do if the sigmoid colon becomes cyanotic after having performed the resection? If the inferior mesenteric vessel was found to be patent it can be reimplanted. If the patient has severe obstruction in superior mesenteric circulation, the superior mesenteric artery can be revascularized with a bypass procedure. Remember that the collateral vessels come from the hypogastric arteries. Pelvic revascularization can insure colonic viability. Those are the basic anatomical causes. There are several, and all are etiologic factors that cause thrombosis of the blood supply of the marginal arteries supplying

the descending and sigmoidal colon. It is important to remember that, as in our patient, the signs of colon ischemia do not occur during operation but several days later.

The symptoms of colon ischemia are illustrated by our patient. He had diarrhea, fever, and marked abdominal distention and tenderness. Abdominal distention may be difficult to evaluate. Once the diagnosis is suspected, it may be verified by sigmoidoscopy at bedside with pitch black mucosa. There is no question at this point of the diagnosis: colon ischemia.

Once you have made the diagnosis of colon ischemia, management is either conservative or surgical and depends upon the degree of ischemia. In ischemia sufficient to cause mucosal cyanosis or ulcerations, patients can be followed conservatively by resigmoidoscopy, etc. Those patients who are felt to have a necrotic colonic wall and a deterioration of clinical course are taken to surgery. Conservative management consists of closely following the patient's clinical course. Subsequently, a number of these people have been shown to develop colonic strictures from areas of ischemia.

Dr. Gerald Ujiki: At the time of operation, the necrotic rectosigmoid was excised. A Hartman's pouch, transverse colostomy and ligation of the descending colon were performed. Following this, the patient did well for approximately two weeks and then had a massive upper GI hemorrhage. Endoscopy was performed at this time. Bleeding was noted in the fundus but the actual lesion could not be visualized. Because of the amount of bleeding, we asked Dr. Neiman to help us to determine the source of bleeding and possibly to stop the bleeding since we felt that the patient could not tolerate another operation.

Dr. Harvey Neiman: In 1972, the first work on embolization therapy was presented. Since that time there have been numerous modifications of the technique such that now, there are several well established embolic materials including autologous clot, gelfoam, detachable balloons, stainless steel coil and bucrylate (a polymerizing compound).

There are numerous indications for embolization therapy; we have listed the major ones in Table 1.

The unifying factor in these patients is often bleeding. Additionally, they are often poor surgical candidates. Generally, angiographic technique allows for control of the bleeding vessel or vessels.

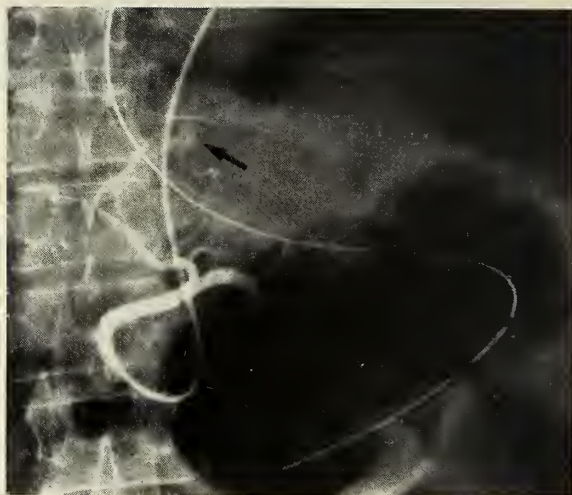


Figure 1.
Identification of bleeding site in stomach by selective catheterization of left gastric artery.

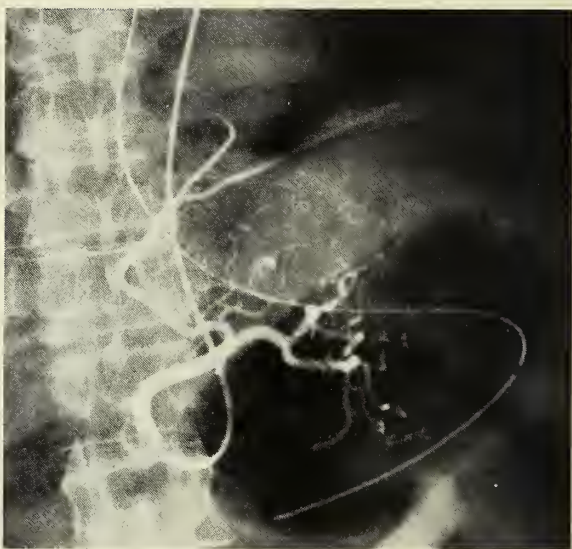


Figure 2.
Bleeding controlled by embolization, using small gelfoam emboli.

In the patient presented we had to approach from the axillary artery because of previous vascular surgery, then superselectively catheterize the left gastric artery. We identified the bleeding site and as was correctly assumed, it is in the fundus of the stomach (Figure 1). This is a characteristic angiographic appearance of an arteriocapillary bleed. It is an extraluminal collection of contrast material that appears in the late arterial phase. Notice that while we have almost completely occluded the various branches of the

left gastric artery, after our first attempt there is still a very small amount of contrast material extravasating. Therefore, there is still an active bleed, and we further embolized the vessel with small gelfoam emboli (Figure 2).

The end result of this procedure is the same as surgically ligating the left gastric artery. The saving grace of either procedure is that the stomach is well vascularized, with multiple feeding arteries. Therefore, it is highly unlikely that the patient would develop necrosis. Many other indications also exist for embolization, as we said, and I would like to discuss some examples of the things embolization can do.

In another case the patient had been wounded by buckshot. There were multiple AV fistulae within the kidney. It was felt that this patient was a candidate for nephrectomy because of massive bleeding from the GU tract. We were therefore asked to study this patient and to see if we could control the bleeding. Following embolization, the patient did very well. There has now been a lot of experience with embolization of kidneys, particularly for A-V fistulae and neoplasms. Interestingly enough, these patients do not develop any early or late sequelae, and in particular, do not develop hypertension.

Another indication is the adjunctive management of neoplasm. In one patient there was a large renal cell carcinoma with massive hyper-vascularity and tumor vascularity supplied from a number of sources. Preoperatively, we controlled the renal artery so that at operation, there was a relatively bloodless field.

Embolization Therapy

Another indication is the use of embolotherapy as a definitive technique. We were asked to evaluate this patient for possible splenic embolization to achieve a nonsurgical splenectomy. This may be occasionally useful in leukemia, for example. Similarly, non-operative patients with hepatic and renal neoplasms may be amenable to this procedure.

There are, of course, risks with embolization therapy as with any invasive procedure. Particularly, there is a risk that embolic material may go to a site that is not the chosen one. Like any surgical procedure or any technical skill, the complication rate in that sense is related to the skills of the individual doing it. Hopefully, that complication will be very low. In most series there is a precarious blood supply and therefore the possibility of necrosis and, perhaps in the spleen, abscess formation. In any case then, we

were fortunate that we were able to stop the bleeding in today's patient.

Dr. Julius Conn, Jr.: The discussants have emphasized the fact that the inferior mesenteric artery did not back bleed when the aneurysm was opened. This is something that everybody doing aortic surgery looks for when the aorta is transected. Unfortunately, is not very helpful in predicting colon ischemia. The absence of bleeding indicates either that the inferior mesenteric artery is already occluded, or that there is inadequate collateral flow from the middle colic artery. I think the mechanism for the colon ischemia patient was not a hypercoagulable state but that his colonic mucosa became ischemic soon after surgery. He then became distended, ate and diverted what small amount of circulation he had to the remainder of his gut. As he became more distended, the serosa, which had a marginal blood supply, necrosed from the intraluminal pressure. Any patient who complains of tenesmus or has bloody diarrhea following aortic surgery, has to be proctoscoped immediately. This man survived because his aortic graft did not become infected although he is still at risk of mycotic aneurysm.

Remember

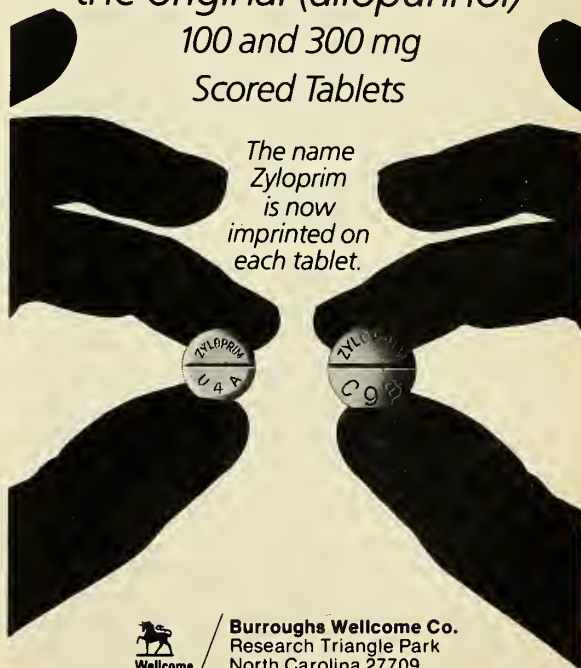
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Serodiagnosis of Mycotic Infections

BY GLENN D. ROBERTS, PH.D./ROCHESTER, MN

Mycotic infections are often diagnostic problems. They may present clinical manifestations similar to such infections as tuberculosis or brucellosis, sarcoidosis, leukemia, lymphoma and other neoplasms. Cultural proof of etiology is considered essential for the definitive diagnosis. This is not always possible and histopathologic evidence of etiology in tissue or the detection of organisms in other clinical specimens by direct microscopic examination are common alternatives.

The etiologic agents of systemic mycoses generally require an extended incubation period of two to six weeks before a definitive identification can be made by the laboratory. *Coccidioides immitis*, an exception, requires one to four weeks for definitive identification. Although cultural proof is preferred, it causes a substantial time

delay in making therapeutic decisions and other diagnostic criteria must be used.

The demonstration of fungi in histopathologic material is often very helpful but may be misleading when used alone. Pathologists who lack experience or interest in mycotic infections often fail to observe fungi in routine Hematoxylin-Eosin stained sections. Special fungal stains, such as the Gomori Methenamine Silver Stain, are often underutilized and could provide valuable diagnostic information if appropriately employed. Careful consideration must be given to the type of tissue response and activity of the infection as well as morphologic features of the fungi, since they often present an atypical appearance. In these instances, one must await definitive culture identification.

Fungal serologic tests are considered a helpful adjunct to diagnosis of mycotic infection when used with clinical and histopathologic evidence. Reliable tests have been developed to detect antibodies in patients having aspergillosis, blastomycosis, candidiasis, coccidioidomycosis, cryptococcosis, or histoplasmosis. A test to detect the capsular antigen of *Cryptococcus neoformans* is

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also available and is highly reliable for diagnosis of cryptococcosis.

These tests often provide the earliest presumptive and, commonly, the only laboratory evidence of mycotic infection. One should remember that fungal serologic tests are most useful when used only as a part of the total available diagnostic information. Clinical presentation, radiographic findings, presence of the etiologic agent in histopathologic sections of tissue or other clinical specimens such as bone marrow, urine, respiratory secretions and cutaneous exudates must be considered when interpreting fungal serologic tests. Since these tests sometimes give false negative and positive results, they should be used only to establish proof of infection and not to rule it out.

Often, too much is expected from fungal serologic tests. The patient who is immunocompromised by an underlying disease process, or chemotherapeutic agents such as corticosteroids or cytotoxic drugs, may have a very rapidly progressive mycotic infection. In this instance, blood for fungal serologic studies may be drawn before an antibody response has had time to occur. In this situation, test results will be negative, which emphasizes why fungal serologic tests should not be used to exclude a diagnosis of mycotic infection.

Many of the antigens used contain components that cross-react with other fungi to give false positive results. For example, the antigens of *Blastomyces dermatitidis* are similar to those of *Histoplasma capsulatum* and *Coccidioides immitis*. Occasionally a patient with blastomycosis will have positive serologic tests to heterologous antigens such as *H. capsulatum*. In most instances, however, the antibody titer is greater to the homologous antigen; *B. dermatitidis* in this case. It is recommended that a battery of antigens be used to more easily interpret cross reactions. In addition, the value of these tests is enhanced if several serial serum samples are tested and a four-fold or greater rise in titer is observed. Positive serologic tests yield not only diagnostic but also prognostic value during the course of chemotherapy. When interpreted appropriately, fungal serologic tests are considered useful and reliable. Their availability seems limited to large medical centers or reference laboratories; however, results are available within two to three days after submission of a specimen. Physicians are encouraged to make optimal use of fungal serologic tests even if specimens must be forwarded to a laboratory outside their own communities.

The following sections describe the tests that

are commonly available and the interpretation of each.

Aspergillosis

Patients having either allergic bronchopulmonary infection, invasive disease or aspergilloma are most commonly infected with *Aspergillus fumigatus*, *Aspergillus niger* or *Aspergillus flavus* and antigens of each are routinely included in the testing battery.

The immunodiffusion (precipitin) test is most commonly used. The presence of one or more precipitin bands suggests active infection. When cultural proof and a compatible clinical picture are present, the tests are diagnostic of active infection. Precipitins are found in the sera of 90% of the patients with aspergilloma and 50-70% of those patients having allergic bronchopulmonary aspergillosis.¹ Antibodies are found less often in patients with disseminated disease but the usefulness of the test has been observed by conflicting reports in the literature.^{2,5} Patients suspected of having invasive aspergillosis should be serologically reexamined at periodic intervals if test results were negative early in the course of infection.

The complement-fixation test is preferred by some laboratories and results differ only by being reported in a quantitative fashion. This test has been shown to correlate well with the number of precipitin bands present: the higher the titer, the greater the number of precipitin bands that will be present.⁶

Blastomycosis

The complement-fixation test is most widely used, but its clinical value is questionable. An antigen prepared from the yeast form of *B. dermatitidis* is used. Positive tests are detectable in less than 25% of culturally proven cases. Titers of 1:8-1:16 are suggestive of active infection; titers of 1:32 are indicative of active infection. Cross reactions occur in the sera of patients having histoplasmosis or coccidioidomycosis and often low titers are detected in sera from patients who have no clinical evidence of blastomycosis. Rising titers demonstrated by testing several consecutive sera are much more reliable for establishing a serologic diagnosis of blastomycosis and usually indicate progressed infection. Decreasing titers have prognostic value and reflect regressed infection.

An immunodiffusion test is now available and is reported to detect 80% of the culturally proven cases with better specificity.⁷ The presence of one or two precipitin bands (designated A and

B) is considered to be a positive test. The disappearance or reduction in number of precipitin bands may have prognostic value.

Candidiasis

The clinical usefulness of serologic tests for the diagnosis of candidiasis is uncertain since numerous conflicting reports have been published. Currently, the immunodiffusion test is thought to be the most reliable. A recent cooperative report shows an 89% sensitivity rate with a specificity of 90%.⁸ Precipitins are found in a small percentage of the normal population, making interpretation difficult. Until the true efficacy of the test is determined, it must be interpreted with caution and used only as an adjunct to clinical findings. Currently, developmental investigations are being performed for detection of circulating antigens of the *Candida* species since antibodies may not be detected during the early acute course of infection.

Coccidioidomycosis

Serologic tests for the diagnosis of coccidioidomycosis have been thoroughly evaluated and are considered highly reliable and useful.

The immunodiffusion test may detect antibody within one to three weeks of the first symptoms of infection. If early coccidioidomycosis infection is suspected, it is necessary that the laboratory be notified to concentrate the serum sample (at least 10 fold) to ensure that precipitin antibodies are detected. The immunodiffusion test is usually positive during the first six months after the onset of infection and is thus useful for diagnosis of more advanced disease. In this instance, the immunodiffusion test gives results that correlate well with the complement-fixation test. It is recommended that the immunodiffusion test be used as a screening tool and that all positive tests be confirmed by the quantitative complement-fixation test.

The latex test for coccidioidomycosis is used by some laboratories for the detection of early precipitin antibodies. The test is overly sensitive and gives false positive results in sera that have been diluted to quantitate results and in cerebrospinal fluid.⁹ Caution should be exercised when interpreting results of the latex test for coccidioidomycosis.

The complement-fixation test is the most widely used quantitative test. Titers of 1:2 to 1:4 are frequently observed in the sera of patients with active infection; however, titers of 1:16 are considered more diagnostically significant. Ele-

vated titers or a continued rise in titer often indicate disseminated infection and patients having such findings should be carefully evaluated. Decreasing titers have prognostic value and usually indicate regressed infection.

False positive tests due to cross reactions to *H. capsulatum* and *B. dermatitidis* may occur but titers are usually higher to the homologous antigen. False negative tests may occur in a few patients having solitary pulmonary nodules. Despite the few false positive and negative results which might be observed, the serologic tests for the diagnosis of coccidioidomycosis are extremely helpful.

Cryptococcosis

Cryptococcosis is rapidly becoming one of the most commonly recognized mycotic infections, particularly in the compromised patient. *Cryptococcus neoformans* is not known to elicit a strong humoral antibody response and common serologic tests for antibody detection are of little use.

However, a latex test which detects the circulating polysaccharide capsular antigen of *C. neoformans* is available and is highly reliable.^{10,11} The presence of capsular antigen in any concentration is diagnostic for cryptococcosis. The test is most useful for detecting cryptococcal meningitis and 95-98% of culturally proven cases have had antigen present in the cerebrospinal fluid. In most instances a companion serum sample will give negative results or the titer will be less than that found in the cerebrospinal fluid. Elevated antigen titers are usually found in the sera of patients with disseminated cryptococcosis, but only 30-40% of patients with localized infections have detectable amounts of antigen present.

False positive tests have been observed only when the rheumatoid factor is present; this may be overcome by including proper controls during testing.¹² The latex test for cryptococcal antigen is commercially available and should be used by all laboratories. Test results provide both reliable diagnostic and prognostic information.

Histoplasmosis

Serologic tests for the diagnosis of histoplasmosis are among those most widely used.

The immunodiffusion test is useful as a screening method for the detection of precipitins which appear early during the course of infection. The M band appears early during infection and remains throughout its duration. It may be present alone and usually indicates early or chronic infection. It may appear, however, in the serum of normal persons known to exhibit delayed hy-

persensitivity to histoplasmin, after a recent skin test.

The H band appears later than the M band and disappears earlier, and its disappearance may indicate regressed infection. The H band rarely appears alone during active infection and its significance, in this instance, is not well understood.

The presence of H and M bands simultaneously indicates active infection¹³ and most often appears in cases of disseminated infection. It should be emphasized that all patients with histoplasmosis do not exhibit H and/or M bands. All sera positive in the immunodiffusion test should be tested with other tests which yield quantitative results.

The most valuable quantitative method is the complement-fixation test. An antigen prepared from the yeast form of *H. capsulatum* detects 75-80% of the active cases. There are instances, however, when antibodies are detected only by an antigen (histoplasmin) prepared from the mycelial form. Both antigens are positive in approximately 10% of the culturally proven cases of histoplasmosis. For maximum sensitivity it is necessary to include both the yeast and mycelial antigens in the test battery.

Titers of 1:8 to 1:16 are suggestive of infection and titers of 1:32 are usually indicative of active infection. A four-fold increase in titer on successive serum samples reflects progressive in-

fection and a decreasing titer indicates regression of the infection. False positive tests with titers as high as 1:128 have been reported in patients without evidence of mycotic infection, but this is relatively uncommon.¹⁴ Moreover, false negative tests may occur in older patients or those with severe advanced disseminated infection. Skin tests given to persons having prior exposure to *H. capsulatum* may produce an elevation of titers to histoplasmin in a small percentage of individuals.¹⁵ In addition, cross reactions occur in patients with aspergillosis, coccidioidomycosis, and blastomycosis, but titers are usually higher to the homologous antigens. If these are given careful consideration when interpreting results, fungal serologic tests will prove reliable and very useful for the diagnosis of histoplasmosis.

Summary

Fungal serologic tests are useful adjuncts to the clinician when correlated with other diagnostic information such as the clinical picture, histopathologic findings and cultural evidence of infection. Although the availability of these tests is limited, an effort should be made to identify a source where they are performed and maximize their use. Fungal serologic tests can add another dimension to the total diagnostic workup of a patient suspected of having a mycotic infection. ◀

References

1. Campbell, M.J., Clayton, Y.M.: "Bronchopulmonary Aspergillosis," *Am. Rev. Resp. Dis.* 89:186-196, 1964.
2. Young, R.C., Bennett, J.E.: "Invasive Aspergillosis Absence of Detectable Antibody Response," *Am. Rev. Resp. Dis.* 104:710-716, 1971.
3. Henderson, A.H., English, M.P., Stewart-Smith G.: "Fungal Infections," *Lancet* 1:502, 1967.
4. Murray, I.G.: "Aspergillosis," *Lancet* 1:373, 1966.
5. Bardana, E.J., Gerber, J.D., Craig, S., Cianciulli, F.D.: "The General and Specific Humoral Immune Response to Pulmonary Aspergillosis," *Am. Rev. Resp. Dis.* 112:799-805, 1975.
6. Gerber, J.D., Jones, R.D.: "Immunologic Significance of Aspergillin Antigens of Six Species of *Aspergillus* in the Serodiagnosis of Aspergillosis," *Am. Rev. Resp. Dis.* 108:1124-1129, 1973.
7. Kaufman, L., McLaughlin, D.W., Clarke, M.J., Blumer, S.: "Specific Immunodiffusion Test for Blastomycosis," *Appl. Microbiol.* 26:244-247, 1973.
8. Kozinn, P.J., Taschdjian, C.L., Goldberg, P. K., et al.: "Efficiency of Serologic Tests in the Diagnosis of Systemic Candidiasis," *Am. J. Clin. Pathol.* 70:893-898, 1978.
9. Pappagianis, D., Krasnow, I., Beall, S.: "False Positive Reactions of Cerebrospinal Fluid and Diluted Sera with the Coccidioidal Latex Agglutination Test," *Am. J. Clin. Pathol.* 66:916-921, 1976.
10. Bloomfield, N., Gordon, M.A., Elmendorf, D.F.: "Detection of *Cryptococcus neoformans* Antigen in Body Fluid by Latex Particle Agglutination," *Proc. Soc. Exper. Biol. Med.* 114:64-67, 1963.
11. Prevost, E., Newell, R.: "Commercial Cryptococcal Latex Kit: Clinical Evaluation in a Medical Center Hospital," *J. Clin. Microbiol.* 8:529-533, 1978.
12. Bennett, J.E., Bailey, J.W.: "Control for Rheumatoid Factor in the Latex Test for Cryptococcosis," *Am. J. Clin. Pathol.* 56:360-365, 1971.
13. Heiner, D.C.: "Diagnosis of Histoplasmosis Using Precipitin Reactions in Agar Gel," *Pediatr.* 22:616-627, 1958.
14. Terry, P.B., Rosenow, E.C., Roberts, G.D.: "False-Positive Complement-Fixation Serology in Histoplasmosis—A Retrospective Study," *JAMA* 239:2453-2456, 1978.
15. McDearman, S.C., Young, J.M.: "The Development of Positive Serologic Tests with *Histoplasma capsulatum* Antigens Following Single Histoplasmin Skin Tests," *Am. J. Clin. Pathol.* 34:434-438, 1960.

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Abstracts of Board Actions

(Continued from page 357)

The Board approved revision of a statement on the dues billing form concerning distribution of voluntary Political Action Committee (PAC) contributions. The new billing form will indicate that "The \$45.00 voluntary contribution supports political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC." The Board action was prompted by a Federal Election Commission complaint charging that IMPAC and nine other state PACs are "affiliated" with AMPAC . . . and because of the affiliation, violated the \$5,000 federal campaign contribution limit. The billing change is designed to avoid future alleged violations under the Commission's interpretation of the term "affiliated."

LEGISLATION

The Board ratified Society action urging Governor Thompson to sign legislation that would:

- Mandate confidentiality of psychiatric records
- Amend the new Mental Health Code to correct "unworkable" provisions
- Mandate that all complaints against physicians go directly to the Medical Disciplinary Board rather than to R&E's administrative offices
- Permit treatment of minors for alcoholism without parental consent for up to three months
- Create a Catastrophic Health Insurance Study Commission to investigate the need for a state catastrophic health insurance program and explore funding methods
- Require the Dept. of Corrections to defend and indemnify physicians it employs who are named in malpractice actions arising from treatment provided during their employment
- Require physicians who dispense—other than by direct administration—a controlled substance in their offices to file a triplicate prescription form with the state . . . and place the drug Preludin in the "designated product" category requiring a triplicate form
- Extend Medicaid coverage to women—pregnant for the first time—who otherwise would become eligible for Public Aid after the birth
- Require review of all existing licensing acts and assessment of all proposed licensing acts prior to introduction in the General Assembly

Also ratified was action urging the Governor to:

- Amendatorily veto—to remove a clerical error—legislation establishing physician advertising guidelines. ISMS supports the bill which conforms to guidelines adopted by the ISMS House of Delegates.
- Veto so-called "sunset legislation" which would repeal all licensing acts over a 10 year period.

ISMS will oppose pending legislation that would:

- Mandate coverage by third parties of independent clinical social workers' services.
- License emergency out-patient medical treatment centers.

CME ACCREDITATION

ISMS has aligned its CME accreditation program with AMA now that the Association has re-established itself as a national accrediting body. At the direction of its House of Delegates, AMA last July withdrew from the Liaison Committee on Continuing Medical Education

(LCCME) which had been the national accreditation authority. However, LCCME retained the support of its other member organizations and will continue accreditation activities, thus creating a dual national system. ISMS will forward accreditation information to LCCME only if such action is advised by legal counsel. In addition, the Board will submit a resolution calling on the ISMS House of Delegates to urge AMA to work toward elimination of dual accreditation at the national level.

KEY MAN PROGRAM

ISMS will mail to state societies in surrounding states information on its highly-effective Key Man Program and encourage those societies to establish similar systems. The move is designed to generate "grassroots" support for ISMS efforts to have AMA implement a national Key Man Program. Over the years, ISMS has introduced numerous resolutions calling on AMA to establish the national program. However, the proposals have been defeated, radically modified or referred for study, thus stifling development. Depending upon budget and staff time constraints, ISMS efforts to encourage and assist other states' key man activities may be expanded.

REVISIONS IN POLICY MANUAL/BYLAWS

In accordance with House of Delegates' action, the Board approved policy statements on the following subjects for inclusion in the Policy Manual: blood availability; smoking; reconstructive surgery; second opinion for surgery; usual and customary or reasonable reimbursement; distribution of information regarding dues and assessments; resident-student alternate delegates to AMA; and specialty society representation on ISMS councils. Deleted from the Policy Manual was a statement on fee schedules.

The Board amended a policy statement—adopted by the House in May—outlining physician advertising guidelines. The statement—"Advertising by radio, TV or billboards is prohibited"—was deleted from the policy statement on advice of legal counsel because it might subject the Society to action by the Federal Trade Commission. The Board will seek ratification of the change at the upcoming House of Delegates meeting.

The Board will introduce resolutions at the next House of Delegates session proposing bylaws revisions—to implement House action—concerning the streamlining of the Interim House session. In addition, resolutions will be introduced calling for bylaws changes to clarify the: (1) Role of AMA delegates in the ISMS House; and (2) ISMS committee structure and provide for several direct-reporting committees not now included in the bylaws.

HOUSE RESOLUTIONS

Acting on resolutions referred to it for study, the Board voted to recommend that the House of Delegates *reject*:

- Resolution 78N-2 calling on ISMS to conduct a study to determine the costs borne by physicians in complying with government programs. Arthur Young & Company developed a proposal—at no cost—for such a study, but concluded that ISMS would be unable to obtain the desired information.
- Resolution 78N-6 directing ISMS to establish a physicians' negotiating agency. The resolution's sponsor requested that the Board oppose adoption, and indicated he will introduce a different proposal at the next House session.

MEDICAID

The Board will submit a resolution at the upcoming House of Delegates session recommending that the House rescind its current policy opposing use of the Social Security number as an identifier. The resolution was prompted by AMA's refusal to allow IDPA to use the medical education number as an identifier on Medicaid claims. IDPA currently obtains—as required by law—a physician's Social Security number when he enrolls in Medicaid.

In other actions concerning Medicaid, the Board voted to urge IDPA to: (1) Adopt a set of ISMS-developed CPT-4 code groupings for common procedures that will simplify the payment process; (2) Clearly define record-keeping requirements for common procedures to avoid potential audit problems; and (3) Allow billing for multiple consultations, but refer questionable consultation patterns to peer review.

ISMS-ILL. PSYCHIATRIC SOCIETY COMPLAINT TO BAR ASSN.

ISMS will join the Ill. Psychiatric Society (IPS) in filing a complaint with the Ill. State Bar Association's Ethics Committee against Cook County Public Guardian Patrick Murphy. Recently, Murphy charged that patients from Manteno State Hospital were used as "guinea pigs" in experimental surgery at the University of Chicago Hospital. IPS conducted a professional and ethical review of the situation and maintains the allegations are baseless. ISMS legal counsel will assist IPS in preparation of the complaint.

LICENSE APPLICATION FORM

ISMS will ask the Dept. of Registration & Education to eliminate three questions from the Physician License Application Form which ask if the applicant has, in the past, suffered from alcoholism, drug addiction or mental illness. ISMS maintains the questions are discriminatory, and do not address the applicant's current ability to practice medicine. The Society will suggest that the three questions be replaced by the following: "Do you presently suffer from any physical or mental limitations or disabilities (such as epilepsy, cardiac disease or alcoholism) which would adversely affect your ability to practice medicine?"

SPECIAL PROGRAMS

Acting on requests concerning special programs, the Board voted to:

- Convene a meeting—involving representatives of IDPH, medical and nursing schools, specialty societies and hospital groups—to consider development and implementation of sexual assault-related training programs in medical schools, residency programs and hospitals. The meeting was requested by State Rep. Aaron Jaffe, chairman of the Illinois Rape Study Committee. ISMS will incur only mailing costs.
- Co-sponsor with the Illinois CPA Society a program—possibly in conjunction with the ISMS annual meeting—on financial topics of interest to physicians and CPAs with medical clients. The session may be the first in a series held in Chicago and downstate. ISMS and the CPA Society would cooperate in program development, and costs would be covered by registration fees.
- Co-sponsor—with the Chicago Nutrition Assn. and Institute of Food Technologists—the 8th Biennial Spring Nutrition Symposium on April 30, 1980, at the Pick-Congress Hotel, Chicago. The program is designed for physicians, dietitians and food technologists. No ISMS financial commitment is involved. ISMS will seek CME accreditation for the session.

ILLINOIS CANCER COUNCIL

The Board endorsed in principle activities of the Illinois Cancer Council . . . and an ICC study titled "Cancer Information Needs in Illinois." The study is aimed at assessing the knowledge, attitudes and behavior of the medically disadvantaged in order to develop effective educational programs concerning cancer risks and benefits of early detection and prevention. The Board also endorsed a recommendation of the National Cancer Institute's site selection committee that the new Medical Institute for Neutron Therapy be located in the Michael Reese Medical Center complex, Chicago. The action was prompted by reports that a Batavia, Ill., site is being considered for the central neutron therapy facility.

SPORTS MEDICINE

ISMS will offer to aid the Governor's Task Force on Sports Medicine in Illinois High Schools in efforts to have a sports medicine coordinating office established within the Illinois Department of Public Instruction. The coordinating office would: (1) Conduct programs to educate physicians, school officials, high school trainers and coaches in sports medicine procedures; (2) Coordinate sports medicine services within the Illinois school system; and (3) Develop legislation aimed at improving the safety of high school athletic competition.

The Society's Sports Medicine Committee will offer its services as an arbitrator to the Illinois High School Association in disputes over the safety of special "assistive" and protective devices used by athletes. Use of various devices frequently is prohibited by school officials who maintain they pose a hazard to other athletes. However, without the devices, some athletes are unable to compete.

IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Lithobid (Lithium Carbodate); Ticrynafen Tablets (Selacryn); Trichotine Vaginal Cleanser; Chronulac (Lactulose) Syrup; Ceclor (Cefaclor); and Betadine (Ointment, Solution, Scrub).

APPOINTMENTS/NOMINATIONS

The Committee on New Health Practitioners was enlarged and made a task force with the addition of the following physicians: *Drs. Bernard Baalman*, Hardin; *Howard Burkhead*, Evanston; *Joan Cummings*, Hines; *Marvin DeHaan*, Wayne; *Melvin Freedman*, Granite City; *Allan Goslin*, Streator; *Boyd McCracken*, Greenville; and *Henri Havdala*, *Daniel Pachman*, *Richard Rovner* and *Randolph Seed*, all of Chicago.

Nominated to fill slots allocated for a psychiatrist and osteopath on IDPA's State Medical Advisory Committee were: PSYCHIATRISTS—*Albert Norris*, Springfield; and *Gustavo Hernandez*, Elmhurst OSTEOPATHS—*Dennis Reter*, Canton; and *Jerrold Schwartz* and *Rodgers Whittington*, both of Chicago.

Dr. Alfred Kiessel, Decatur, was appointed to the ISMS Third Party Payment Processes Committee and the Joint ISMS-Illinois Hospital Association Program Committee responsible for developing a series of one-day seminars on "JCAH's New Standards of Care and How to Meet Them" . . . and *Dr. Boonmee Chunprapha*, Hinsdale, was appointed to the ISMS Peer Review Appeals Committee.

Anticipating that the Legislature will override the Governor's veto of legislation transferring administration of the Division of Services for Crippled Children from the Univ. of Illinois to the Illinois Board of Vocational Rehabilitation (IBVR), the Board agreed to nominate the following physicians for appointment to an advisory board mandated by the new law: *Drs. James Heersme*, Mt. Vernon; *Ned DuVivier*, Alton; *Leo Markin*, Chicago; *Robert Hart*, Peoria; and *Robert Kraus*, Decatur. The Board also endorsed the Illinois Hospital Association nominations of *Drs. Henry Betts* and *Margaret O'Flynn*, Chicago, for appointment to the board. While transfer of the program would not take place until next July, the act provides for the immediate establishment of the board which will advise the IBVR director.

Nominated for appointment to AMA posts were: *Dr. Sandra Olson*, Chicago—AMA Committee on Women Physicians in Organized Medicine; and *Dr. Boyd McCracken*, Greenville—AMA Council on Medical Education's new Committee on Accreditation of CME. The Board also endorsed the candidacy of *Dr. Jack Gibbs*, Canton, for election to the AMA Council on Medical Education. ◀



Illinois State Medical Inter-Insurance Exchange

The physician-owned
professional liability
insurance program

The Exchange is Redeeming Guaranty Fund Certificates

The Exchange is redeeming Guaranty Fund Certificates held by retired physicians* and the estates of deceased physicians. Letters, mailed in late October, informed eligible Certificate holders of the procedure to follow for redemption. If you have retired from practice and have not received a redemption letter (or if you know of someone in this category), please inform one of our Communication Service Counselors at (312) 782-1654.

Certificates securing in-force policies are not eligible for redemption.

*Retired Members are those who have been regular members and who by reason of age or incapacity have retired from active practice. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.



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ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

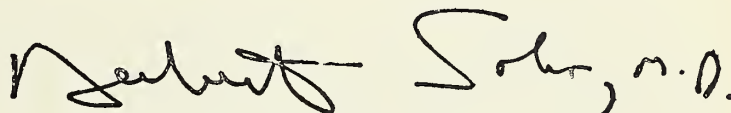
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This page is the IMPAC Council's attempt to provide you with information regarding your medical political action committee. For months, you have read of IMPAC's activities and many of you have returned the coupon provided with this page along with your check to join IMPAC.

Soon you will be receiving your 1980 dues billing and IMPAC membership solicitation. I hope that when you make your check out, a generous contribution to IMPAC will be included. If not, we have failed in our efforts through this page. Or perhaps nobody cares. Do you?

Show you care -- support the Illinois Medical Political Action Committee.



Herbert Sohn, M.D.
Chairman

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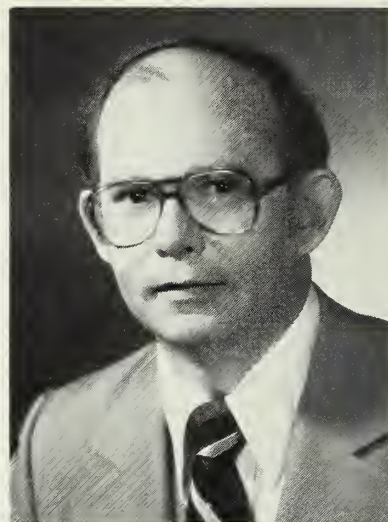
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The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Dictating The Circumstances

People who get on in this world are the people who get up and look for the circumstances they want, and if they can't find them, make them.

George Bernard Shaw



As patient advocates, physicians have a responsibility to develop creative solutions to health care problems. Often times, that responsibility requires our involvement in circumstances we would prefer to avoid.

The national health insurance issue has fostered considerable debate, with medicine's stance consistently being perceived as "anti." The term "anti" carries the unmistakable connotation of negativism. However, our "anti" posture in this case embodies many positive considerations, most noteworthy being our concern for patients.

As the debate has raged, many participants have narrowed their perception of alleged "cracks" in the health care system. The belief that a comprehensive NHI system is needed has been transformed into a conviction that a catastrophic plan is the answer. Interestingly, some of the most persuasive arguments for a sweeping NHI program have been anecdotal references to the economic consequences of catastrophic illness.

Undeniably, the cost of catastrophic illness has—in some cases—resulted in economic disaster. Are these circumstances isolated, or are we confronted with a widespread problem? Our analysis of the catastrophic issue produced only one conclusion: There is a paucity of hard data to either support or refute the need for a catastrophic insurance program.

Before we can formulate a solution, we must define the problem. ISMS steadfastly has maintained that flaws in the health care system can be effectively remedied without government intervention. However, the lack of hard facts about the catastrophic coverage issue prompted ISMS to successfully back legislation creating a governor's commission which will study the need for a catastrophic plan.

The hard data generated by the commission will give us a clear picture of the situation and enable us to deal with facts. If the commission uncovers a genuine need for a catastrophic plan, we have an obligation to our patients to be the leaders in meeting that need.

The circumstances we want may not always be there. But the circumstance we must prevent is the encroachment of government into medicine because of misinformation or the profession's lack of initiative. That is our responsibility to our patients. ◀

A handwritten signature in dark ink, reading "P. John Seward, M.D." The signature is fluid and cursive, with a large initial "P" and "J".

P. John Seward, M.D., President

Doctor's News

PROBLEM PRODUCT REPORTING PROGRAM ANNOUNCES TOLL-FREE NUMBER—

The U.S. Pharmacopeia has announced that a 24-hour toll-free telephone number is now available to persons participating in the Problem Product Reporting Program (PRP).

PRP, coordinated by the U.S. Pharmacopeia under contract with the FDA Bureau of Drugs and Medical Devices, allows health care professionals to report problems experienced with drugs, medical devices and *in vitro* diagnostic products. The FDA has encouraged health professionals to report hazardous or potentially hazardous products, mislabeling or improper labeling, incomplete or confusing instructions, erroneous information, designs that encourage human error, performance failures, non-sterile products, packaging errors, defective components, quality control or any other problems which could affect the safety and efficacy of a given product.

Callers should be prepared to provide their name, zip code, phone number, the product name, strength, size, lot number and expiration date, (if applicable and available) date purchased and source, (if known) manufacturer's name and address and labeler's name and address, if different from the manufacturer, and the problem noted.

The toll free telephone number is 800-638-6725.

ISMS ALIGNS CME ACCREDITATION PROGRAM—The ISMS Board of Trustees recently voted to recognize the AMA as the primary national accrediting authority for CME, with the understanding that the state medical associations, in accordance with guidelines by the AMA Council on Medical Education, will be recognized immediately as accrediting bodies for institutions and organizations providing local and intrastate programs of continuing medical education. The ISMS Committee on CME Accreditation was instructed to forward reports of its decisions to the AMA Department of Continuing Medical Education. The Board further voted to introduce a resolution at the House of Delegates' Interim Session this month, urging that AMA work to eliminate dual national accreditation authority.

In a memo to Illinois' accredited CME Sponsors., Robert R. Hartman, M.D., Chairman, ISMS Board of Trustees, reported the above, emphasizing that present accredited status was *not* affected. Further, the R&E Medical Examining Committee is expected to accept credit earned from sponsors accredited by (or under the auspices of) the AMA, LCCME or other sources as recognized by the Department.

IN A RELATED NOTE—All Illinois medical licenses will be subject to renewal by the Illinois Department of Registration and Education as of July 1, 1980. Forms for license renewal will be mailed next spring.

Illinois law requires that continuing medical education (CME) credit be earned during a pre-license renewal period. Statutes stipulate that at least 50 hours of Category 1 and an additional 50 hours of Category 2 credit be earned by each physician during the two year period April 1, 1978 through March 31, 1980. Of the 50 hours Category 1 credit, a minimum 20 must be part of an approved, formal educational program as specified in the Act. The balance may fall into the realm of approved teaching or medical care audit activities.

NEW STATE TAX AFFECTS PARTNERSHIPS, CORPORATIONS—Because Illinois' new "replacement tax"—which supercedes the corporate personal property tax—is being challenged in the Ill. Supreme Court, physicians are advised to file corporate & partnership returns under protest. A court decision striking down the tax then would qualify physicians for a refund. Returns filed without protest would not be eligible for a refund regardless of the court's decision.

The new tax—which took effect July 1—ended a nine-year controversy that began when the 1970 State Constitution mandated abolition of the corporate personal property tax & enactment of a "replacement" by Jan. 1, 1979. The General Assembly failed to replace the property tax, but the Supreme Court ruled in March that it had expired, even though it had not been replaced.

The new law's tax liability may be greater than that under the personal property tax system . . . and altered by special provisions dealing with trusts, estates, etc. Physicians are advised to consult their personal tax advisor to accurately determine the "replacement tax's" impact.

CONTROLLED SUBSTANCES UPDATE—Physicians are advised that statutory requirements for triplicate prescriptions for amobarbital, secobarbital and pentobarbital have expired. Regular prescription blanks may be used when prescribing these three drugs.

PHYSICIANS IN THE NEWS—**Olga Jonasson, M.D.**, Chicago, the first woman to head the surgical department of a major medical center in the U.S., received the 1979 Alumnae of Northwestern University Award last month. Chief of Surgery at Cook County Hospital, Dr. Jonasson was the first female member of the Society of Clinical Surgery and the first surgeon to perform a kidney transplant at the UI Hospital, where she is chief of the transplant surgery division and a former president of the medical staff . . . **James E. McDonald, M.D.**, Oak Brook, and **Thomas J. Stamm, M.D.**, Elmwood Park, recently received the 1979 Stritch Medal of the Loyola University Stritch School of Medicine for their work in establishing an organization to provide eye care in countries lacking ophthalmologists. Dr. McDonald, chairman of the Ophthalmology department, and Dr. Stamm, clinical professor of ophthalmology, established FOCUS, Inc., in 1961. An amalgam for "Foreign Ophthalmological Care from the United States," FOCUS is a nonprofit Illinois corporation headquartered at the Loyola University Medical Center Department of Ophthalmology. The organization enables physicians to donate their time and talents for a month working in FOCUS clinics, which now exist in Haiti, Guatemala, Columbia and Nigeria. Since 1961, 120 American physicians have served 179 months in tours of service. Each agreed to donate a month away from their own practices serving one of the clinics, paying personal expenses, including transportation . . . **George T. Wilkins, Jr., M.D.**, Granite City, 1977-78 ISMS president, was recently named to the Board of Trustees for Southern Illinois University in Carbondale.

NOTE FROM THE ARTHRITIS FOUNDATION—The National Arthritis Foundation has announced that continuing medical education materials for physicians are available from their local chapters upon request. Materials include notice of seminars and scientific meetings in rheumatology, handbooks and articles, as well as audio cassettes. Interested physicians are invited to contact the Arthritis Foundation at 3400 Peachtree Road, N.E., Suite 1101, Atlanta, GA 30326, or telephone (404) 266-0795.



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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

December

Family Therapy

Law of Child Abuse and Family Therapists
For: MD's, therapists. Workshop, Dec. 7-8, Chicago. Speaker: Sandra Nye, JD, MSW. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$90. Reg. limit: 100. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Forensic Medicine

Forensic Pathology and Clinical Forensic Medicine
For: MD's, attorneys. Case presentations, every Thursday, 2:00 p.m., Chicago. Sponsor: Office of the Medical Examiner, Cook County, IL, 1828 W. Polk St., Chicago 60612. Reg. deadline: none. Fee: none. Reg. limit: none. Contact: Robert Stein, MD. Phone: 312/443-5017.

Internal Medicine/Family Practice

Clinical Allergy for Practicing Physicians
For: MD's. Symposium, Dec. 6-8, St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$160. Reg. limit: 150. Credit: AMA Category 1, 15 hours; AAFP Prescribed, 15 hours. Contact: Loretta Giacometto. Phone: 314/367-9673.

Medicine

Orthopaedics (Hand/Wrist/Forearm/Foot)
For: MD's. Symposium, Dec. 5, 1:00 p.m., Nashville. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Lake County Medical/Surgical Seminar
For: MD's, DO's, DDS's, RN's, RPH's. Seminar, Dec. 12, 8:00 a.m., Waukegan. Sponsor: St. Therese Hospital, 2615 Washington, Waukegan 60085. Reg. deadline: 12/10. Fee: \$3. Reg. limit: none. Credit: AMA Category 1, 5 hours; AOA Category 2, 5 hours; AAFP Elective, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Medicine

Clinical Immunology
For: MD's. Symposium, Dec. 8, 1:00 p.m., Mt. Carmel. Sponsor: SIU School of Medicine, 801 N. Rutledge, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Neurology

Neurology for the Non-Neurologists
For: MD's. Workshop, Dec. 12-14, 8:30 a.m., Sheraton Plaza Hotel, Chicago. Sponsor: Rush University, Office of Continuing Education, 600 S. Paulina, Chicago 60612. Reg. deadline: 12/7. Fee: \$250. Reg. limit: 150. Credit: AMA Category 1, 18 hours. Contact: Harold Paul, MD. Phone: 312/942-7095.

Obstetrics/Gynecology

Annual Course in Colposcopy for the Practicing Physician
For: Gynecologists. Course, Dec. 7-8, Chicago. Sponsor: Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Co-sponsors: Prentice Women's Hospital and Maternity Center. Fee: \$250. Reg. limit: 100. Credit: AMA Category 1, 13 hours. Contact: Lori Dorfner. Phone: 312/649-8536.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Dec. 19, 1:00 p.m., Forest Park. Speaker: Jack Mabley, columnist. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Surgery

Specialty Review in Thoracic Surgery

For: General & Cardiothoracic Surgeons. Lecture, Dec. 10-14, Chicago. Speaker: Sidney Levitsky, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 200. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

January

Alcoholism

Current Concept of Alcoholism

For: GP's, fulltime specialty. Lecture, Jan. 9, 1:30 p.m., Chicago. Speaker: David Lichtenstein, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Family Medicine

Sports Medicine—Physical and

Psychological Aspects

For: MD's. Lecture, Jan. 16, 1:00 p.m., Holiday Inn, Glen Ellyn. Speaker: Richard Dominguez, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Widmer.

Family Medicine

10th Annual Winter Refresher Course

for Family Physicians

For: FP's. Course, Jan. 16-18, Pfister Hotel, Milwaukee, WI. Sponsor: Dept. of Family Practice, The Medical College of WI, Seton Tower, 2315 North Lake Drive, Milwaukee, WI 53211. Co-sponsor: S.E. Chapter of the Wisconsin Academy of Family Physicians. Fee: \$160. Reg. limit: 225. Credit: AMA Category 1, 20 hours; AAFP Prescribed, 20 hours. Contact: Susanna Rechltz. Phone: 414/291-0813.

Family Therapy

Techniques for Working with Severely Dysfunctional Families

For: MD's. Workshop, Jan. 18, 9:30 a.m., Chicago. Speaker: Froma Walsh, PhD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$45. Reg. limit: 75. Credit: AMA Category 1, 6 hours. Contact: Jeanne Robinson. Phone: 312/649-7285.

Medicine

Hepatobiliary Disorders

For: MD's. Symposium, Jan. 17, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Lake County Medical/Surgical Seminar

For: MD's, DO's, RN's. Symposium, Jan. 30, Waukegan. Sponsor: St. Therese Hospital, 2615 Washington St., Waukegan, IL 60085. Reg. deadline: 1/28. Fee: \$3.00. Reg. limit: none. Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours; AOA, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Medicine

Infectious Diseases

For: MD's. Symposium, Jan. 31, 1:00 p.m., Carlinville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

MEDICINE FOR TODAY

31st Annual Program American Academy of Family Physicians

Sessions run October, 1979 thru March, 1980. Credit: AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. Fee: AAFP members, \$110; nonmembers, \$125. Courses will be conducted at the following locations:

Belleville—St. Elizabeth's Hospital
Berwyn—MacNeal Memorial Hospital
Beverly—Little Company of Mary Hospital
Centralia—St. Mary's Hospital
Chicago Nearwest—St. Francis Cabrini Hospital
Chicago North—Swedish Covenant Hospital
Chicago Southwest—Christ Hospital
Harvey—Ingalls Memorial Hospital
Hinsdale—Hinsdale Sanitarium and Hospital
Mattoon—Sarah Bush Lincoln Health Center
Melrose Park—Westlake Community Hospital
Park Ridge—Lutheran General Hospital
Peoria—St. Francis Hospital
Rockford—Swedish American Hospital
Rock Island—Rock Island Franciscan Medical Center
Springfield—St. John's Hospital

For complete information contact:
IAFP, 1200 Harger Road, Suite 405, Oak Brook, IL 60521. Phone: 312/325-8502.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Jan. 16, 1:00 p.m., Forest Park. Speaker: Paul Wender, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Surgery

Specialty Review in General Surgery,

Part II

For: Surgeons. Lecture, Jan. 14-25, Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$500. Reg. limit: 400. Credit: AMA Category 1, 99 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Surgery/Gastroenterology

Disorders of the Esophagus

For: MD's. Symposium, Jan. 11, 10:45 a.m., Oak Park. Speaker: S. Alshabkhoun, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Peptic Ulcers—Diagnosis and Management

For: MD's. Symposium, Jan. 18, 10:45 a.m., Oak Park. Speaker: John Howser, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Management of Upper Gastrointestinal Bleeding

For: MD's. Symposium, Jan. 25, 10:45 a.m., Oak Park. Speaker: Robert Freeark, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

February

Clinical Cardiology

Aminoglycoside Therapy

For: MD's. Symposium, Feb. 6, 10:45 a.m., Oak Park. Speaker: Gordon Trenholme, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Clinical Applications of Electrolyte Studies

For: MD's. Symposium, Feb. 13, 10:45 a.m., Oak Park. Speaker: Stanley Bakshy, PhD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Management of Anaerobic Infections in Clinical Practice

For: MD's. Symposium, Feb. 20, 10:45 a.m., Oak Park. Speaker: Herbert Sommers, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Clinical Cardiology

Radioimmunoassays and Their Diagnostic Significance

For: MD's. Symposium, Feb. 27, 10:45 a.m., Oak Park. Speaker: C. Vugrinic, PhD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Medicine

Allergy

For: MD's. Symposium, Feb. 21, 1:00 p.m., Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Office Counseling—Practical Aspects

For: MD's. Symposium, Feb. 13, 8:00 a.m., Belleville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Sixth Annual Postgraduate Course on Internal Medicine

For: MD's. Symposium, Feb. 8-9, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 10 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Follow-Up Immunology

For: MD's. Symposium, Feb. 5, 7:00 p.m., Vandalia. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Sexuality

For: MD's. Symposium, Feb. 23, 8:00 a.m., Benton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Neurology

The Basic Science of Neurology:

A Comprehensive Review

For: Neurologists, Neurosurgeons. Lecture, Feb. 18-22, Chicago. Speakers: Frank Rubino, MD; Sandro Olson, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Neurosurgery

Specialty Review Course in

Neurological Surgery

For: Neurosurgeons. Lecture, Feb. 1-10, Chicago. Speaker: Leonard Kranzler, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$500. Reg. limit: 250. Credit: AMA Category 1, 104 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

Obstetrics

Teenage Pregnancy

For: GP's, Obstetricians. Lecture, Feb. 13, 1:30 p.m., Chicago. Speaker: Atef Moawad, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Feb. 20, 1:00 p.m., Forest Park. Speaker: Richard Fisch, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Surgery/Gastroenterology

Pathology of Inflammatory Diseases of the Bowel

For: MD's. Symposium, Feb. 1, 10:45 a.m., Oak Park. Speaker: A. Zarif, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Antibiotics in Colon Surgery

For: MD's. Symposium, Feb. 8, 10:45 a.m., Oak Park. Speaker: Frank Ashley, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Radiological Diagnosis of Ileitis & Colitis

For: MD's. Symposium, Feb. 15, 10:45 a.m., Oak Park. Speaker: John Gall, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Management of Ileitis & Colitis

For: MD's. Symposium, Feb. 22, 10:45 a.m., Oak Park. Speaker: Raymond Teplitz, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery/Gastroenterology

Management of Diverticular Diseases of the Colon

For: MD's. Symposium, Feb. 29, 10:45 a.m., Oak Park. Speaker: M. Z. Sait, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

RECENT CME ACCREDITATION DECISIONS

The ISMS Committee on CME Accreditation has approved the CME programs of the following institutions:

Belleville Hospital Association for CME

Columbus-Cuneo-Cabrini Medical Center, Chicago

Gottlieb Memorial Hospital, Melrose Park

Illinois Central Community Hospital, Chicago

Illinois Society of Allergy and Clinical Immunology

Provident Hospital, Chicago

Ravenswood Hospital Medical Center, Chicago

Riverside Hospital, Kankakee

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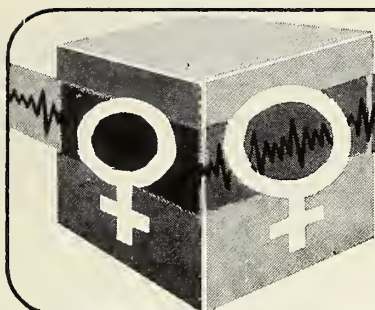
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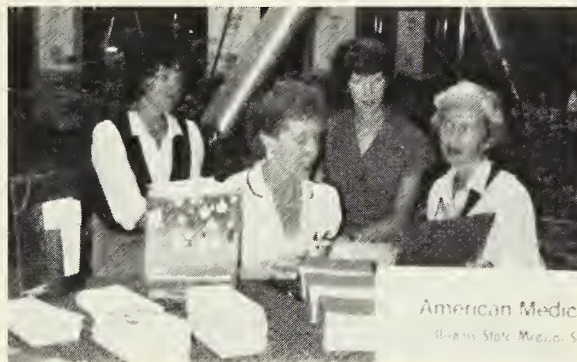
MRS. R. SAMUEL HOOVER WITH MRS. WAYNE KASSEL

Ferryl, Vitamina and Pernicious? Sounds like heavy fare for first, second and third graders, but these three are three of the most popular puppet characters in the classrooms of Will-Grundy, Kankakee, and Vermilion counties. Medical Auxiliary members from Joliet, Danville, and Kankakee began presenting "Nutrition" puppet shows three years ago and have made this an ongoing project.

The puppet drama seen by the children is part of a health education program promoted by the ISMSA, but under local direction of the county medical society auxiliaries. The puppet show is presented to the primary level to supplement their classroom nutrition unit. Auxiliary members administer and direct the program and, along with Junior High drama students, perform the play.

The nutrition program for the 1979-1980 year of the ISMSA will continue its focus on the education of the child, but extend itself further to the home via packaged material. To introduce the program, the ISMSA Nutrition Chairman, Mrs. Wayne Kassel, presented a most successful workshop at the ISMSA Fall Conference in Bloomington on October 17. Lynn Kassel also introduced the "nutrition package" to over 350 Auxiliary members from all over the United States at the American Medical Association Leadership Confluence in Chicago, on October 7-9, 1979.

Mrs. Kassel and the Will-Grundy Medical Society Auxiliary members have prepared a package which contains sample materials and guides to setting up nutrition programs in the schools. The first item in the package is a letter of intro-



Pictured above (l-r) with ISMSA nutrition display, Mrs. Eugene Wittenstrom, Kane County, Mrs. Wayne Kassel, Will-Grundy, Mrs. Francis Dunn, Kane County and Mrs. R. Samuel Hoover, ISMSA president.

duction regarding nutrition objectives:

- To educate the child
- To bring information into the home
- To help make the information functional on a community level (through the PTA, local health fairs, or school lunch review programs)

The ISMSA nutrition package includes a guide to approaching the school, scheduling shows, and using a volunteer force of puppeteers and drivers. Also enclosed are copies of two different plays now in use and a photograph of the stage and puppets with building plans for the stage as well as information on buying and/or making the puppets. Finally publicity ideas and a sample of the package to go to the child's home are included.

The homebound package is an important next step in the education program. First of all, each child will receive a coloring book about the four food groups after viewing the puppet play. Sec-

only, the "home" package will be distributed. The package will contain a short letter explaining the drama, crediting the local medical auxiliary and suggesting that the materials be used by all family members. A chart of the four food groups with color food pictures, plus information on vitamins, minerals, proteins, carbohydrates, and fats will be included. The chart covers several levels of sophistication and is printed in both English and Spanish. Also included will be a table listing the nutritional and caloric values of fast food favorites and a listing of "good for you" snacks as alternatives to some of today's popular food snacks. The package is printed on brightly colored paper and is most attractive and eye catching.

Bringing basic nutrition information to the home and community is a long range objective of the Illinois State Medical Society Auxiliary. Hopefully, this new, attractive home nutrition package will help us accomplish this goal and point out to the community that the physician's auxiliary is vitally interested in educating our children about this most important health issue, proper nutrition. ◀

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Review in Neurological Surgery
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Specialty Review in Psychiatry
March 10-14, 1980

Clinical Medicine Update
March 17-21, 1980

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Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief

1 = Partial relief

2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400^{TABLETS}mg
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- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

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Motrin® (ibuprofen)

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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

EKG

(Continued from page 361)

Answers: 1. C.D. 2. A. C. D.

In the top ECG rhythm strip, the fourth and the eighth beats are premature atrial beats with aberrant intraventricular conduction. Close scrutiny of the T wave of the preceding sinus beats revealed a tenting of the T wave not present in other sinus beats. These are ectopic P waves on the T waves. The PR interval of these premature beats is much longer than the normal sinus beats. Once the lidocaine bolus was given, a greater degree of atrioventricular slowing occurred. Therefore, the pauses seen after the second and ninth sinus beats in the middle strip and after the fifth and eighth beats in the bottom strip are caused by non-conducted or blocked premature atrial beats. A compensatory pause means the cycle containing the premature beat is equal to two sinus cycles. The premature atrial beats here and in general do not have compensatory pauses because they will reset the sinus pacemaker. Lidocaine was initially given here because these beats were thought to be premature ventricular beats. No more lidocaine was given. These premature atrial beats responded to digitalization. ◀

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MED B-4-S



To the ISMS Board of Trustees

AAMA, Illinois Society, President Reports

Following is the text of a report given by Cissy A. Egly, CMA, president, Illinois Society at the recent meeting of the Illinois State Medical Society Board of Trustees.

"Dr. Seward, Dr. Hartman, Members of the Board of Trustees — Representing the American Association of Medical Assistants, Illinois Society, I appreciate the opportunity to report to the Board of Trustees. As many of you may already know, the primary purpose of AAMA and the Illinois Society is to provide quality education for our members and your employees, as Medical Assistants. A little more than a year ago, AAMA was recognized by HEW; thereby supporting our efforts with federal monies in continuing to provide the best in education of our members. As in the past, the Illinois Society continues to provide educational programs throughout the state, to members and non-members alike. Certification is also available to these Medical Assistants who wish to study and sit for the examination; thus providing your medical office with an employee who cared enough to upgrade the quality of duty performance, as a benefit to you, as well as to your patients. Even though these benefits are available to all employees of ISMS members, we have seen a membership drop of 200 in the past year and a half; our membership count today is 672. A great number less than one medical assistant per each member (13,000) of ISMS. Though, at this point in time, we recognize a need for the physician support in their employees becoming a member of AAMA, Illinois Society. Our national office is, at present, surveying past members in search of reasons for non-renewal, so the we might, in the future, be able to concentrate our efforts in these areas for membership retention and increased membership interests. Since we do not have the entire membership of ISMS with us today, my questions are addressed to you, as members of the Board of Trustees. Do you personally support our non-union professional organization of 23 years? If

so, we thank you for your continued support. If you do not support our organization, we need to know your reasons of non-support. If you do support us, how many of your employees belong to the Illinois Society? How many do not? For those employees who do not belong, what are their reasons for not being members? Maybe the fault lies with our Society, in that we have failed to avail our support to the members of ISMS. A thought to ponder, realize the full impact of our potential (13,000) membership supporting your ideas on proposed legislation and perhaps lobbying in Springfield in support of ISMS legislation. We are available as loyal employees to assist you. We welcome your question, suggestion and/or thoughts on increasing our membership from the ranks of ISMS member employees."

Convention Update

Many AAMA Illinois Society members attended the AAMA 23rd Annual Convention in New Orleans, LA., where they took part in a full week of education sessions and an active part in the business session of the House of Delegates. Over 1,000 Medical Assistants, Students, and Educators, including Medical Assistants from Canada, Alaska and Hawaii were in attendance.

Dr. John L. Wright, Chairman of the AAMA Physician/Advisory Board (Bloomington, IL) reported that the Advisory Board continues to encourage physician participation and support of the American Association of Medical Assistants.

The Certifying Board reported that the June 1979 Certified Medical Assistant (CMA) examination was administered in 110 test centers with 2,419 Medical Assistants attaining Certification.

If you or your Medical Assistant would like more information about AAMA, please contact: Cissy A. Egly, CMA, President, 1413 Midland Court, Joliet, IL 60436 or Luella V. Mitchell, Chairman, Public Relations Committee, 7920 Eberhart Avenue, Chicago, IL 60619.

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UROLOGIST—GEORGIA: Medium-size city of twenty thousand and new 150-bed hospital needs full time urologist in private practice. First year gross estimated over \$100,000. Attractive office space and financial assistance available. Family oriented community with attractively priced homes, excellent schools, and plenty of outdoor recreation. Send curriculum vitae in confidence to: Mr. William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia 30338.

OPHTHALMOLOGIST—GEORGIA: Established group with renowned Southern reputation desires colleague to handle busy office practice. Attractive office space and new 125-bed accredited hospital. Pleasant family community with private schools and complete recreation facilities, e.g., golf, boating. Send curriculum vitae in confidence to: Mr. Grady White, Search Director 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia 30338.

GENERAL PRACTICE—FLORIDA: Pleasant small town near University of Florida Medical Center needs an additional GP. Financial guarantee plus free office space adjacent to hospital. Send curriculum vitae in confidence to: Mr. Grady White, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia, 30338.

INTERNIST—Board eligible or certified to join two surgeons in rural area. Active incorporated clinic with new hospital and clinic facilities located in the upper midwest. For more information contact Clinic Manager, Kingsbury Clinic, Lake Preston, SD 57249 or phone 605-847-4448 or 605-847-4214 evenings.

ALLERGIST—ABAI Certified/eligible wanted for far west suburban Chicago allergy practice; part time basis initially (one or two days) leading to full association. Please send resume to Illinois Medical Journal, P.O. Box 953, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

SEEKING FIFTH PHYSICIAN to complete career-oriented Emergency Medicine Group. Full time staffing Emergency Department, 550 bed teaching hospital, major affiliation with University of Illinois. Excellent specialty back-up. Breaking ground for brand new Emergency Department in September. Excellent salary and generous conference allowance, 48-hour week, malpractice, life, health, disability, 4-week paid vacation. Send CV to: Jim Thomas, M.D., 221 N. E. Glen Oak Avenue, Peoria, Illinois (309) 686-1529.

KENTUCKY EMERGENCY PHYSICIAN—Lovely community of 10,000 in western Kentucky near Paducah needs two physicians to share evening rotations in the emergency department. 10 to 15 patients per 12-hour shift. Income excellent for

this volume. For additional details, contact Tom Cooper, M.D., 970 Executive Parkway, St. Louis, Missouri 63141, or call toll free 1-800-325-3982, ext. 225.

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PART-TIME EMERGENCY ROOM PHYSICIANS. 48-60 hours monthly. 12 hour night shifts. Malpractice insurance paid. Excellent backup coverage. 45 minutes SW of Chicago. Contact M. Longanacker, Adm., P.O. Box 326, Joliet, IL 60434. 815-744-2800.

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LOOKING FOR DERMATOLOGIST, ALLERGIST, UROLOGIST, NEUROLOGIST interested in full or part time employment with potential for full participation in group. Leased space arrangements also available. Contact Lawrence A. Geiser, Business Administrator, Blue Island Medical Center, 13000 S. Maple Avenue, Blue Island, Illinois—or call 312/385-6100.

ILLINOIS, Northern: Openings for 3 full-time Emergency Dept. Physicians for a 450 bed hospital, with 36,000 visits yearly in large urban area. The hospital is affiliated with Loyola University. Salary will be based on experience and quality of work. Malpractice and Health Insurance will be paid. Contact: Physicians Emergency Service at (312) 792-3807, 7447 W. Talcott, Suite 314, Chicago, IL 60631, or Dr. Amito Sircar, Medical Director, Emergency Dept., Resurrection Hospital (312) 744-8000.

WANTED: GENERAL PRACTITIONER to join well established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E. Walnut Street, Green Bay, Wis. 54301. Telephone 414-437-4366.

BOARD ELIGIBLE OR BOARD CERTIFIED general plastic surgeon to work with high volume facial plastic surgeon, Dr. Annette M. Lotter. Position immediately available. Terms to be discussed. Call Chicago, 312-266-1977.

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Illinois Medical Journal

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DECEMBER, 1979

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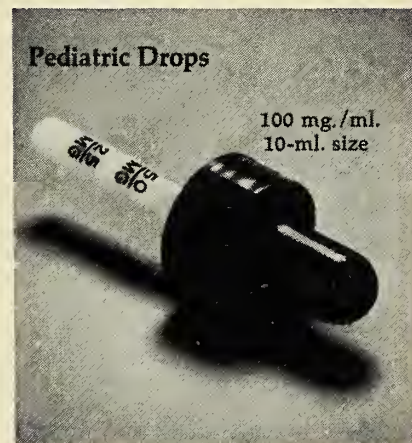
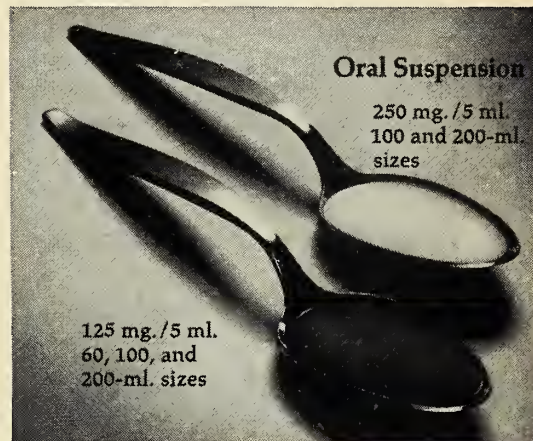
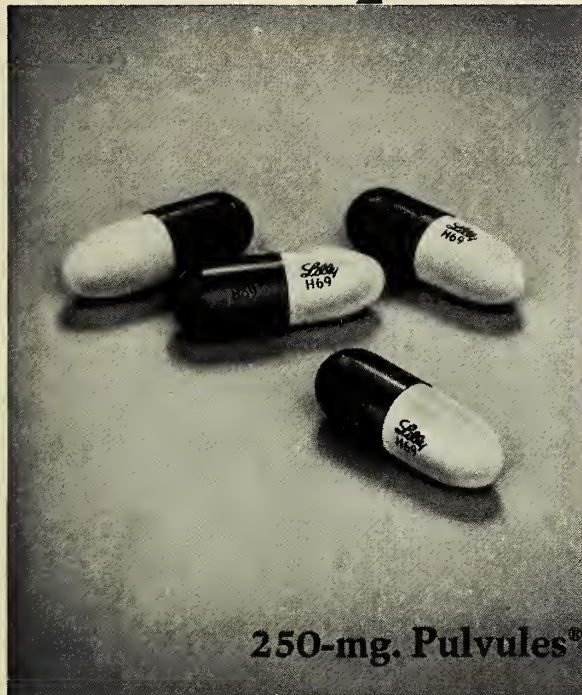
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Editorials



Art and Science

This month's *Journal* includes an article entitled, "Hispanos: Impact of Culture on Health Care," by Pedro A. Poma, M.D., which merits comment.

Many persons outside our profession may view medical care purely as a scientific and technological exercise. Dr. Poma's article brings into focus an essential component of physicians' art: empathy.

In reading his treatment of countervailing forces which have impact on relationships with our patients, many may reflect upon the equally suspended joys and frustrations of medical practice. Clearly, a balanced perspective of the patient's cultural beliefs and psychological needs plays a significant, albeit subconscious role, in designated treatment plans.

The highly transient nature of modern society may limit the pleasure of long-term physician-patient relationships. Few of us now maintain patients and their families from birth to adulthood.

Still, Dr. Poma's article elicits the point that expanding knowledge does enable a physician to enjoy personal satisfaction. Technology and motility combined will never replace the doctor as healer. ◀

J. William Roddick, Jr., M.D.
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March 9-15, 1980

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All Illinois physicians' licenses are due for renewal July 1, 1980. Your 100 hours of required CME credits must be earned between the period starting April 1, 1978 and ending March 31, 1980.

Sunday, March 9, 1980

HYPERTENSION SEMINAR. *Chairman:* John H. Laragh, MD, Cornell Medical Center, New York. *Speakers:* John H. Laragh, MD (New York); Frank A. Finnerty, Jr., MD (Washington, D.C.); Ray W. Gifford, Jr., MD (Cleveland); Francesco del Greco, MD (Chicago); Thomas A. Keith, III, MD (Cincinnati); David T. Lowenthal, MD (Philadelphia); Colman Ryan, MD (San Francisco); and Robert C. Tarazi, MD (Cleveland).

Monday, March 10, 1980

WHAT'S NEW IN MEDICINE? SEMINAR. *Chairman:* Michael E. DeBakey, MD, Baylor College of Medicine, Houston. *Speakers:* Michael E. DeBakey, MD (Houston); Marco Caine, MD (Jerusalem, Israel); Frank H. DeLand, MD (Lexington, Ky.); Bernard F. Germain, MD (Tampa); David L. Horwitz, MD (Chicago); Ruth Jackson, MD (Dallas); Leon O. Jacobson, MD (Chicago); Alfred S. Ketchum, MD (Miami); George R. Prout, Jr., MD (Boston); William Schumer, MD (Chicago); Ronald J. Scott, MD (Fort Lauderdale); James I. Tennenbaum, MD (Columbus, OH); C. Craig Tisher, MD (Durham); and Harrison D. Willcutts, MD (West Springfield, MA.).

Tuesday, March 11, 1980

DIGESTIVE DISEASES SEMINAR. *Chairman:* Arvey I. Rogers, MD, University of Miami. *Speakers:* Arvey I. Rogers, MD (Miami); Martin Kalser, MD (Miami); Joe U. Levi, MD (Miami); Eugene Schiff, MD (Miami); Leon Schiff, MD (Miami); and Elliot Weser, MD (San Antonio).

Wednesday, March 12, 1980

CANCER SEMINAR. *Chairman:* R. Lee Clark, MD, University of Texas System Cancer Center, Houston. *Speakers:* R. Lee Clark, MD (Houston); Roy Ashikari, MD (New York); Hugh R. K. Barber, MD (New York); Albert Bothe, Jr., MD (Boston); Frank H. DeLand, MD (Lexington, KY.); Philip R. Exelby, MD (New York); Victor Fazio, MD (Cleveland); Alfred S. Ketchum, MD (Miami); Gerald P. Murphy, MD (Buffalo); George R. Prout, Jr., MD (Boston); and Charles L. Vogel, MD (Miami).

Thursday, March 13, 1980

UROLOGY SEMINAR. *Chairman:* George R. Prout, Jr., MD Harvard Medical School (Boston). *Speakers:* George R. Prout, Jr., MD (Boston); Marco Caine, MD (Jerusalem, Israel); Robert Krane, MD (Boston); Edwin M. Meares, Jr., MD (Boston); Frederick K. Merkel, MD (Chicago); Gerald P. Murphy, MD (Buffalo); Thomas J. Rohner, Jr., MD (Hershey, PA.); and Robert H. Rubin, MD (Boston).

Friday, March 14, 1980

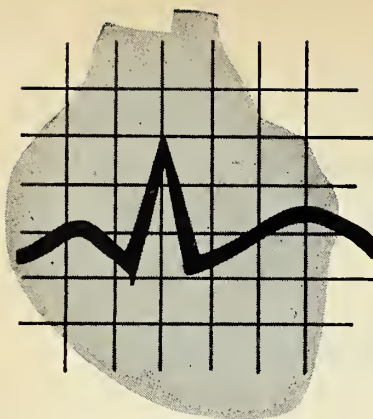
NUTRITION/HYPERALIMENTATION SEMINAR. *Chairman:* George L. Blackburn, MD, PhD, Harvard Medical School, Boston. *Speakers:* George L. Blackburn, MD, PhD (Boston); Bruce R. Bistrian, MD, PhD (Boston); Johan Bjorksten, PhD (Madison, WI.); Albert Bothe, MD (Boston); David L. Horwitz, MD, PhD (Chicago); Herbert P. Sarett, PhD (Evansville, IN.); Philip L. White, ScD (Chicago); Harrison D. Willcutts, MD (W. Springfield, MA.).

Saturday, March 15, 1980

COSMETIC SURGERY SEMINAR. *Chairman:* Pierre Guibor, MD (New York).

TUTORIALS AND WORKSHOPS — including Acid-Peptic Disorders and seven other topics.

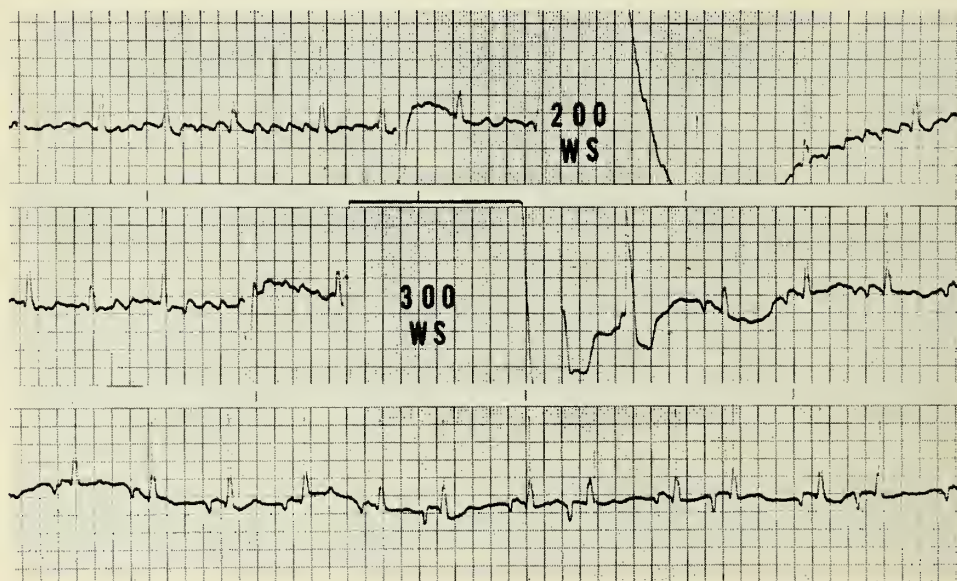
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID J. HALE, M.D.,
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JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

The patient is a sixty year old sales manager who began getting dyspnea on exertion some two months prior to his office visit. He was now becoming breathless upon ascending a half flight of stairs or walking one block down the street. He was sleeping well and otherwise felt healthy. His physical examination demonstrated normal lung findings. Examination of the heart was normal except for a third heart sound, which resembled an opening snap but was not followed by a diastolic rumble. A chest X-ray and a twelve lead electrocardiogram were normal. M-mode echocardiography demonstrated a mass in the left atrium and behind the mitral valve. Cardiac angiography confirmed the presence of a left atrial myxoma. Open heart surgery was performed and the myxoma was removed. On the third post-operative day, a cardiac arrhythmia developed and was treated. This continuous ECG rhythm strip was recorded at a second hospitalization two months after his open heart surgery.



Questions:

1. The ECG rhythm strip shows:

- A. Atrial fibrillation with a controlled ventricular response.
- B. Two direct current (D.C.) countershocks of 200 watt-seconds and 300 watt-seconds.
- C. Sinus rhythm with distorted P waves.
- D. Sinus rhythm with premature atrial beats in bigeminy.
- E. All of the above.

2. The following statement(s) is/are true:

- A. The restoration of normal sinus rhythm following direct current (D.C.) cardioversion is only possible if the heterotopic

pacemakers are more sensitive to D.C. countershock than the sinus node pacemaker.

- B. D.C. cardioversion can often be lifesaving and large doses of anti-arrhythmic drugs are no longer necessary.
- C. D.C. cardioversion of a cardiac arrhythmia caused by digitalis intoxication is contraindicated except as a desperate lifesaving measure.
- D. D.C. cardioversion is indicated when restoration of sinus rhythm is considered definitely beneficial.
- E. All of the above.

(Continued on page 468)

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CONRAD HILTON HOTEL
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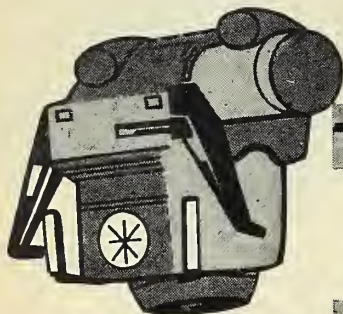
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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was submitted by Bruce Silver, M.D., an assistant professor of radiology at the Loyola University Medical Center in Maywood.

This 29-year-old black male reported recurrent abdominal pain for several months. A double contrast enema was performed. Spot film sigmoid is included.



Figure 1



Figure 2

What's your diagnosis?

1. Porphyria
2. Ulcerative colitis
3. Chron disease
4. Cholecystitis

(Continued on page 471)

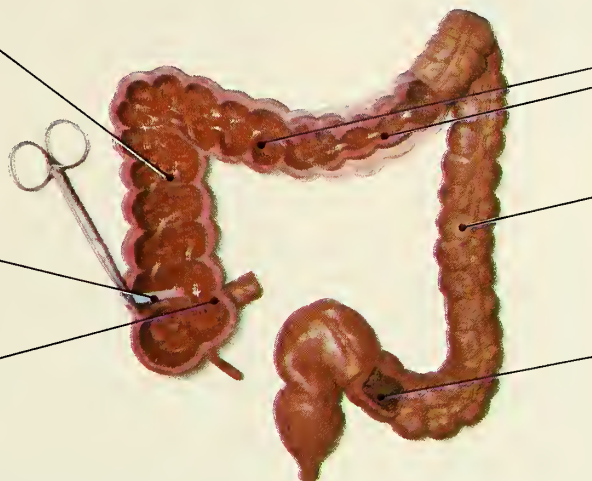
Unique colon-specific non-systemic mode of action

No enzyme capable of breaking lactulose down to its constituent monosaccharides exists in the human small intestine¹. Hence, lactulose passes through the small intestine unchanged and unabsorbed to reach the colon. Within 5 minutes² normal colonic bacteria institute the chain of events illustrated below.³ The repeated stimulus to the colon's own propulsive activity helps restore normal function with no evidence of tolerance⁴⁻⁷. Twenty-four to 48 hours may be required to produce a normal bowel movement.

3. Degradation to low molecular weight acids markedly increases the number of osmotically active molecules present

2. The acid metabolites cause a drop in pH.

1. 97% of the Chronulac dose reaches the colon unchanged and bacterial breakdown to low molecular weight acids begins.



4. The acid pH and osmotically assured water content stimulate the colon's own propulsive activity.⁸

5. The colon's natural electrolyte transfer tends to restore a neutral pH and the water content maintains stool softening.

6. A dose-responsive stool of increased weight, volume, and moisture content results⁸ usually within 24 to 48 hours. No evidence of tolerance to the drug has been reported.⁴⁻⁸

Laboratory-monitored freedom from adverse reactions

avoids the potentially harmful effects of the repeated use of traditional laxatives

Laboratory measurements⁷⁻⁹ failed to elicit any drug related changes in blood elements, serum electrolytes, enzyme activity, or blood calcium and magnesium concentrations variously tested in patients and normal subjects who had received lactulose daily for periods up to 6 months. When daily treatment of elderly and debilitated patients must be continued beyond 6 months, it is recommended that serum electrolytes be checked before treatment is continued.

No evidence of tolerance, long-term

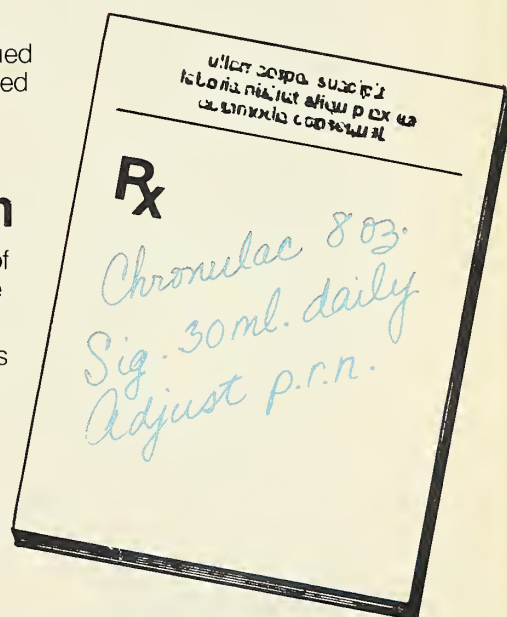
Clinical studies have failed to demonstrate the need to increase doses of lactulose with long-term treatment. Once established, the effective dose can be maintained.

In one study of 82 patients, 57 took daily doses of Chronulac for periods ranging from more than a month up to a year.⁸ No patients developed tolerance to Chronulac. Fifteen patients actually ended the period of treatment on a lower dose than their starting dose.

Double-blind placebo-controlled proof of efficacy

See next page for brief summary of prescribing information.

R_x only



Chronulac®

(lactulose) Syrup Rx only

- restores bowel function with no evidence of tolerance
- avoids the potentially harmful effects of repeated use of traditional laxatives
- colon-specific mode of action—non-systemic
- proven efficacy and safety—even long-term
- available only on prescription

Chronulac® (lactulose) Syrup

CAUTION: Federal law prohibits dispensing without a prescription.

Brief Summary

INDICATION: For the treatment of constipation. In patients with a history of chronic constipation, lactulose syrup (Chronulac) therapy increases the number of bowel movements per day and the number of days on which bowel movements occur.

CONTRAINDICATIONS: Since Chronulac contains galactose (less than 2.2 g./15 ml.), it is contraindicated in patients who require a low galactose diet.

WARNINGS: **Use in Pregnancy:** Studies in laboratory animals (mice, rats, rabbits) have not revealed a teratogenic potential of Chronulac. The safety of Chronulac syrup during pregnancy and its effect on the mother or the fetus have not been evaluated in humans. The physician and patient should understand that the possibility that Chronulac might cause damage to the human fetus cannot be excluded. Chronulac should not be given during pregnancy unless, in the opinion of the physician, the possible benefits outweigh the possible risks. **Use in Nursing Mothers:** There are no data on secretion of Chronulac in human milk or effect on the nursing infant. **Use in Children:** There is insufficient experience to recommend a dose of Chronulac that is safe and effective for treatment of constipation in children. **PRECAUTIONS:** Elderly, debilitated patients who receive Chronulac for more than six months should have serum electrolytes (potassium, chloride, carbon dioxide) measured periodically. Also, since Chronulac contains galactose (less than 2.2 g./15 ml.) and lactose (less than 1.2 g./15 ml.), it should be used with caution in diabetics.

ADVERSE REACTIONS: Initial dosing may produce flatulence and intestinal cramps, which are usually transient. Excessive dosage can lead to diarrhea. Nausea has been reported. **OVERDOSAGE:** There have been no reports of accidental overdosage. In the event of overdosage it is expected that diarrhea and abdominal cramps would be the major symptoms. Medication should be terminated. **DOSE AND ADMINISTRATION:** The usual dose is 1 to 2 tablespoonfuls (15 to 30 ml., containing 10 g. to 20 g. of lactulose) daily. The dose may be increased to 60 ml. daily if necessary. Twenty-four to 48 hours may be required to produce a normal bowel movement.

Note: Some patients have found that Chronulac may be more acceptable when mixed with fruit juice, water, or milk.

Product Information as of April, 1979

References: 1. Dahlqvist, A. and Gryboski, J.D.: Inability of the human small-intestinal lactase to hydrolyze lactulose. *Biochim. Biophys. Acta* 110:635-636, 1965. 2. Bond, J.H., Jr. and Levitt, M.D.: Investigation of small bowel transit time in man utilizing pulmonary hydrogen (H_2) measurements. *J. Lab. Clin. Med.* 85:546-555, 1975. 3. Hoffmann, K., Mossel, D.A.A., Korus, W., and van de Kamer, J.H.: Investigations on the mode of action of lactulose (β -galactosido-fructose) in the human intestine. *Klin. Wschr.* 42:126-130, 1964. 4. Mayerhofer, F. and Petuely, F.: Investigations regarding the regulation of the intestinal activity in adults with the aid of lactulose (bilidus factor). *Wien. Klin. Wschr.* 71:865-869, 1959. 5. Eustathios, K.G.: The treatment of chronic constipation by lactulose. *Galenos* 11:411-419, 1969. 6. Losner, I.: Lactulose: a clinical study in a chronically constipated geriatric population. *Clin. Med.* 76:24-25, 28-29, 1969. 7. Watson, J.S. and Ebert, W.R.: Lactulose, a new bowel regulator. *Clin. Med.* 76:24-26, 1969. 8. Data on file. MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 9. Sanders, J.F.: Lactulose syrup assessed in a double-blind study of elderly constipated patients. *J. Amer. Geriatr. Soc.* 26:236-239, 1978.

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Obituaries

***Bartelson, Raymond E.**, Chicago, died October 30, 1979, at the age of 67. Dr. Bartelson was a 1937 graduate from Northwestern University Medical School. He was an emeritus staff member of Ravenswood Hospital.

***Bavor, Herbert J.**, Decatur, died October 5, 1979, at the age of 64. He was a 1940 graduate from Case Western Reserve University in Ohio and had served on the staffs of both Decatur Memorial and St. Mary's hospitals.

***Cahill, George B.**, Largo, FL, formerly of Flossmoor, died October 20, 1979, at the age of 73. Dr. Cahill was a radiologist for 40 years with Mercy and Little Company of Mary Hospitals. He was a 1931 graduate from the University of Minnesota.

****DelChicca, Silvio**, Chicago, died November 3, 1979, at the age of 76. Dr. DelChicca was a 1927 graduate from the University diFirenzi, Italy.

***Gburczyk, Frank H.**, River Forest, died October 21, 1979, at the age of 85. Dr. Gburczyk was a 1916 graduate of the Loyola University Stritch School of Medicine.

***Klaus, Rolf Ferdinand**, Chicago, died October 19, 1979, at the age of 77. Dr. Klaus was a 1943 graduate of the Chicago Medical School.

***Klaren, Earl V.**, died October 12, 1979, at the age of 58. Dr. Klaren was a 1945 graduate of the University of Illinois Medical School. He had served as a member of the ISMS House of Delegates, representing Lake County.

****Lusk, William Weis**, Carlinville, died September 17, 1979, at the age of 71. Dr. Lusk was a 1937 graduate of Rush Medical College.

***Marcus Anna A.**, Chicago, died October 30, 1979, at the age of 73. Dr. Marcus was a 1930 graduate of the Chicago Medical School. Dr. Marcus was also a member of the ISMS House of Delegates.

***Pace, Nick F.**, Naperville, died November 6, 1979, at the age of 54. Dr. Pace was a 1953 graduate of the University of Illinois.

***Pomaranc, Mark M.**, Chicago, died October 17, 1979, at the age of 63. Dr. Pomaranc was a 1941 graduate of the Northwestern University School of Medicine.

***Schoenwetter, Arthur H.**, Chicago, died October 30, 1979, at the age of 68. Dr. Schoenwetter was a 1936 graduate of St. Louis University.

***Shoger, Gilbert**, Chicago, died November 5, 1979, at the age of 68. Dr. Shoger was a 1940 graduate of the Chicago Medical School.

****Stilwell, Leland, M.T.**, Champaign, died in October 1979, at the age of 77. Dr. Stilwell was a 1929 graduate of the University of Illinois Medical School.

****Tankel, Katherine M.**, Peoria, died October 17, 1979, at the age of 86.

****Wajay, Rosemary**, Chicago, died October 31, 1979, at the age of 79. Dr. Wajay was a 1926 graduate of the Chicago Medical School.

****Willy, Ralph G.**, Portal, Arizona, formerly of Chicago, died September 5, 1979, at the age of 86. Dr. Willy was a 1916 graduate of Rush Medical College. He served as chairman of the radiology department at Evanston Hospital, assistant professor in radiology at Northwestern Medical School and attending staff at Swedish Covenant Hospital.

***Wizgird, Joseph P.**, Wilmette, died September 16, 1979.

***Yap, Simeon**, Homewood, died September 8, 1979, at the age of 49. Dr. Yap was a 1955 graduate of the University of Santo Tomas Medical School, Philippines.

* Indicates ISMS member

** Indicates ISMS member of the fifty year club



A Responsibility Shared By All

What Will Become Of Cook County Hospital?*

BY LINDA HUGHEY HOLT, M.D./CHICAGO

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey Holt, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

For many years, Cook County Hospital has been a model of the big-city public hospital. By the time this article goes to press, the current Cook County Hospital crisis will no doubt have been resolved, but at the moment of this writing, whether or not County can meet its next payroll is hanging in the balance. The threat to Cook County Hospital's existence sounds a sad note to our Second City's ability and willingness to care for its poor. The closure of County would have far-reaching and ominous implications for every other hospital in the city and state.

Many factors created the current health care crisis at CCH. Inflation, increasing health care costs, and tightening of public budgets have whittled away at every hospital's ability to remain financially solvent. Two trends in public payment for health care specifically have crippled CCH, which is dependent on public funds for most of its budget. First, by changing regulations and complicated bureaucratic procedures, the IDPA has made collection of hospital fees for eligible patients difficult. Most hospitals lose money on Public Aid patients; a hospital such as CCH which is heavily dependent on Public Aid payments suffers while the other hospitals can more readily pad on the extra costs to "paying" patients' bills. Second, Illinois has not changed its definition of poverty level for the purposes of Medicaid eligibility in years. The current maximum family income for qualifying for Public Aid

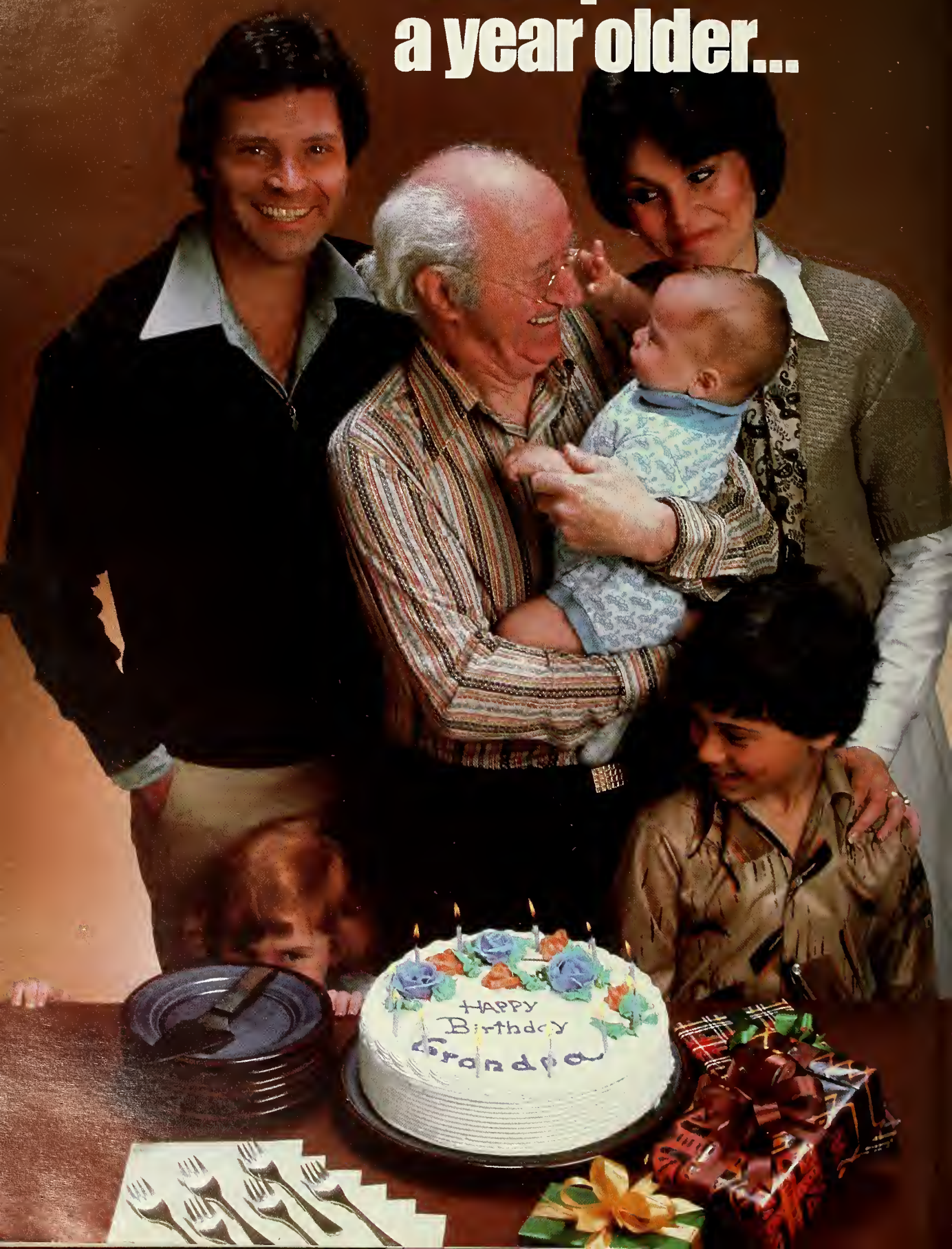
is \$4000.00. This cutoff creates a "working poor" who neither qualify for public assistance nor can afford hospitalization. All Illinois hospitals are in the unpleasant bind of either having to absorb a loss on these patients or trying to squeeze every possible dollar from someone who has few resources. In practice, many so-called "working poor" quickly decide to become non-working, lower-income poor in order to qualify for basic health care benefits of Medicaid. CCH has long been the city's caretaker for the poor; CCH is hit the hardest by the freezing of the qualifying income for Medicaid at a fixed dollar amount while inflation drives the actual income cutoff down.

Several alternatives have been proposed. Many would like to see CCH closed and its patients redistributed "evenly" to other city hospitals. Illinois residents who staff area Emergency Rooms know well that the "evenly" theory would be a fiasco; in reality the burden would fall on a few neighboring hospitals, and the surrounding hospitals with a social conscience would bear the worst of the burden. Every resident in the city has received transfers from other hospitals; patients whose major difficulty was an inability to pay for care. No hospital can provide free care to large numbers of patients. Unless the State offers some facilities for those unable to pay,

(Continued on page 450)

*This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.

Grandpa's a year older...



and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years—

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged. Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate—despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic bronchopulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease*; *persons in chronic care facilities*.

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

More than ever he may need

PNEUMOVAX[®]
(Pneumococcal Vaccine, Polyvalent | MSD)

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summary of prescribing information.*

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PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent [MSD])

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature		Pneumococcal Types													
U.S.	1 2 3 4 6 8 9 12 14 19 23 25 51 56														
Danish	1 2 3 4 6A 8 9N 12F 14 19F 23F 25 7F 18C														

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe

Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials

For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

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Housestaff News

(Continued from page 447)

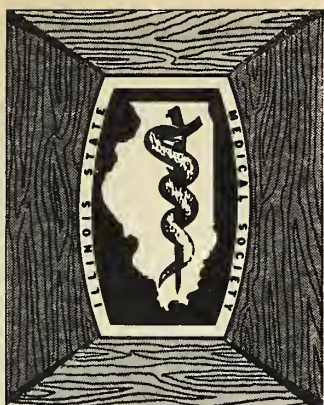
large numbers of patients will be bounced from hospital to hospital receiving poor care and ultimately escalating costs rather than saving money for the State.

Other proposals for solving the CCH crisis include: (1) a massive one-time loan to CCH, (2) Increased tax support of the hospital, and (3) Restructuring of the Public Aid payment system. None of these solutions is perfect. No one is in favor of higher taxes. On the other hand, a loan or outright gift to the hospital would ease the immediate financial crunch but would not, in the long run, solve the income versus costs discrepancy which CCH faces.

The underlying issues of the current crisis will be of critical concern to Illinois resident physicians both during residency and while in practice. The Illinois health care system must deal with the following issues: (1) What constitutes "poverty" from the standpoint of ability to pay the medical costs of the future? (2) Who will pay for the "poor," i.e., those not able to pay medical costs (many of whom are not able to afford current health care costs)?

Historically Cook County Hospital has shouldered much of the responsibility for the city's poorer citizens. Practically every major city in the U.S. has at least one and usually several public facilities with a major commitment to providing health care to people who cannot afford private medical care. In the best of all possible worlds, each hospital and each physician would feel an institutional and personal commitment to serve impoverished patients. In the best of all possible worlds, the State of Illinois and the City of Chicago would not need any public hospitals. But the world we live in is far from perfect.

We, as physicians in training and as citizens, have a responsibility to the thousands of patients cared for each year at Cook County hospital. The financial crisis at Cook County Hospital affects all of us. Unless the physicians of Illinois help to develop a long-range plan for providing health care to the poor, the current crisis at Cook County Hospital will directly affect every health care provider in the state. ◀



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Impact of Culture on Health Care

HISPANOS

BY PEDRO A. POMA, M.D., F.A.C.O.G., F.A.C.S./CHICAGO

Physicians must be sensitively aware of the rich, traditional lore that affects many of their Hispanic patients' concepts of the etiology and cure of disease, particularly since these patients will probably not volunteer the information. Tactfulness and respect for authority are so ingrained in Hispanos that they may even seem to accept a prescription when, in fact, they reject it. Migrants may be lonely, find English difficult, and find it easier to express confidences in Spanish. Translators must be carefully chosen. The Hispanic family is closely knit, ruled by the father. Even in sickness, help can only be sought from outsiders at the cost of family pride. Disease is a punishment. Certain folk diseases are best recognized and treated by a folk healer (curandero). Spells cast by witchcraft, fright due to lightening or a death, the evil eye, bad air, and obstruction (empacho) due to wrong food, all can cause traditional folk diseases. Concerns regarding menstruation and diseases of infants are common. All hospital staff members, even ancillary personnel, may be considered knowledgeable sources about modern medicine; therefore they should be given appropriate information.

Nearly a million Hispanos reside legally in Illinois, about one-fourth of them in Chicago.¹ These individuals differ as widely as all other human beings, and the gamut of their personal

beliefs and practices is extensive. And yet, certain cultural attitudes peculiar to many of them can determine how they perceive illness, when and how they avail themselves of medical services, and the mode in which they comply with the advice and prescriptions of their physicians.

To achieve a therapeutic effect, physicians must be aware of this cultural background so that they can understand their Hispanic patients and be understood by them.

This paper is intended to present those aspects of their cultural heritage that can make treatment of Hispanic patients a particular challenge. This communication is not an extensive review of the literature, nor is it an interpretation or evaluation of the beliefs and practices described. Rather, it is a summary of observations made



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both in the author's native country, Peru, and in Chicago during years of post-graduate study, and private practice, in daily contact with Hispanic patients of various nationalities.

The U.S. Office of Management and Budget defines Hispanic persons as those having their origins in Mexico, Puerto Rico, Cuba, Central and South America, and other Spanish cultures regardless of race. They present a rainbow of colors and shades. The noun, Hispano, does not have an ethnic connotation, but a cultural one. Hispanos are Latinos, but the two groups are not identical. (Latinos are persons having their origins in countries where the languages are derived from Latin, *i.e.*, Spanish, French, Italian.²) Hispanos are an increasingly larger group; in 1976 they accounted for 8% of the total U.S. population (16.5 million) and during the same year an additional estimated 7.5 million¹ were in the United States illegally.

Persons with Spanish surnames are not necessarily Hispanos, nor are they necessarily able to understand or to speak the language. Spanish surnames occur in other European and some Asian countries and may be acquired by marriage or other legal procedures.

Chicanos comprise the largest group of Hispanos in this country. Many are descendants of Spaniards, Mexicans and Mestizos, who lived in the States, principally in the south, for many years before those states joined the Union. Others are more recent Mexican migrants having similar physical characteristics. Mestizos are children of parents from different ethnic groups (Spaniards frequently intermixed with the native populations, and later with other immigrants to the territories or kingdoms they conquered). Many Mestizos believe interracial mixing produces superior individuals. It is difficult to speak of race in countries where Mestizos comprise a large segment of the population. In the "melting pot" of this country, the blending of attributes and qualities of different peoples (not necessarily by interracial marriages) has produced the richest, strongest, most developed nation of the world. What is more, since modern travel and communication permit persons of different origins to better know one another, new attitudes have developed. The strong lines separating races are fading.

The Spanish Language

Language, in addition to the Catholic faith, is considered one of the most important legacies

of Spain to its former colonies. Castellano (Castilian) is the official language of most countries "South of the border." This language originated in Castilla (Castile, Spain) and became Spain's official language during the rule of King Alfonso X, the wise (1252-84).³ In 1713, King Phillip V created the Royal Academy of Language "to cultivate, set standards for purity and elegance of the tongue."³ Since then, purity of the language has been emphasized as a source of pride. With minimal regional variations, most countries have maintained traditional Castilian. But in Central and North America the influence of native language and dialects has been notorious and the more obvious variations are in the local slang. Language, as a living entity, changes continuously; word meanings may make an about-face rotation during a single generation.

As has been seen in other cultures, persons who live where the dominant language is not their own may develop a hybrid dialect that combines their mother tongue and the language of the land. Some Hispanos residing in this country speak such a dialect. To communicate with them, one needs to speak in both English and Spanish, or in the special dialect. In the dialect, English verbs may be conjugated according to the rules of Spanish grammar, English nouns and adjectives transformed into Spanish verbs and English verbs transformed into Spanish nouns. Similarly, Spanish verbs may be conjugated according to English rules, and so on. The conversation may change from English to Spanish and vice versa within the same sentence, all following an established pattern. Some persons cannot communicate in either English or Spanish, and when pressured to choose are unable to proceed. They can express some ideas only in one language and other ideas only in the other language. They may even appear to understand a conversation in one language when actually they do not.

Most Hispanos agree that English is vital for survival and especially for progress in this society. Many parents want their children to be proficient in both languages, and teaching Spanish is a family responsibility. On the other hand, in major cities, many persons may be born, live, love, work, and die without being required to speak English. These persons remain isolated from the society at large; they live in a different world. Persons who speak a different language live in a truly different world, not merely the same world with different labels. The language one speaks affects the way one perceives the en-

vironment, values it, and thinks about it.⁴

In major cities, newspapers, magazines, TV and radio programs, sports, jobs, stores and recreational facilities are available in Spanish. Recently, the quality of spoken and written language available to the Spanish community has improved somewhat.

For mature persons, who have grown accustomed to certain trends of thought, styles and customs, learning another language is difficult. English grammar is unlike Spanish. Pronunciation changes with no apparent pattern, and is inconsistent. Word emphasis usually precedes last syllable, while in Spanish it is usually on the last syllable.

Some sounds in the English language do not exist in the Spanish language. The first generation of children do not find this a difficulty, and usually speak without an accent.

In order to learn another language, one must mimic the speech activity and mannerisms of other persons. (The hand gestures that mean "come here" and "go away," for example, are opposite in English and Spanish).

Repeating the speech of another person is not considered becoming, especially to men, nor is it independent, mature behavior.

The wife-mother role tends to be a conservative one. As keeper of tradition and homemaker, the woman resists changes and new ways. What she knows, and has tested and proven by experience, has to be better.

A return to the "old country" is always considered a possibility even after many years ("I would learn English if I planned to stay.")

Courtesy decrees that the language spoken in a gathering be one all present understand. English then may be formal, impersonal and necessary in dealing with the outside world, at work. For the newcomer, clinging to the old patterns, there is a constant need for translation. Few associations can be made between the sounds of the words and the emotions, images, or memories they may evoke as occurs spontaneously when persons grow up with a language. "I love you" is only eight letters, it is just another foreign sound, and the emotion or the commitment that this phrase represents may be missing. The sounds must be transformed into familiar images, (Spanish images) for their meaning to be grasped, and, then, to express oneself, the process must be reversed. Comprehension by telephone is even more difficult. Slowly, as thoughts and dreams begin to occur in English, the acculturation process advances. The length of the process varies depending on many factors, several of which are per-

sonal, such as the resistance to a foreign culture ("my own is good and proven"). Later on, when newcomers have accepted the new culture, they may be more purist than the native born.

Still, for many, Spanish remains the language of the family, the vehicle of intimacy, the mode of expression during stress situations (sickness, rage, exhaustion). During periods of dependance and regression, psychological defenses move to early mechanisms and to Spanish thought processes. Intimate situations, marital and sexual matters, are easily expressed in the maternal tongue. Despite confidence in "anglo" physicians in other situations, many persons may travel long distances to find a physician of a similar background, who is aware of the implications of certain specific problems and the conflicts they may cause.

Migration

Migration causes separation anxiety and loneliness. Executive families share this feeling even when they simply relocate in another part of their own country, although they are more cosmopolitan and already speak English. The move is traumatic. The migrant must break old ties, make new friends, adapt to new schools, new customs, new neighbors, new climate, and the absence of familiar places and faces. For the man of the family, this trauma may be ameliorated by the new challenges and the opportunity to move upward. His job will keep him busy most of the day. The trauma is more severe for the wife and children.

Any separation causes anxiety; a new situation brings new, independent decisions and the decision-making process is anxiety-provoking. The migrant is faced with many unknowns, including the new customs and language. Sharing the old language with other migrants gives the feeling of an extended family, the sense of belonging, and emotional security. The language is also a barrier that protects newcomers from the curiosity of on-lookers in a land that does not understand and may be threatening.

Social Manners

In general, Hispanos prefer tactfulness and diplomacy in their interpersonal communication. They usually will not express their views to anyone they don't know very well, unless they can take time to differ tactfully. On many occasions, they may appear to agree even when they disagree, and as a result, instructions they are given or accepted deals may not be carried out. His-

panos tend to help others preserve dignity; they show concern and respect for others' feelings. American society values openness, frankness, directness, simplicity, all of which may appear to be blunt, rude, and disrespectful to Hispanos. It is common for bosses, and teachers to ask to be called by their first names. This is difficult for some Hispanos who have been taught to address their superiors with deference. Unfortunately, Americans often consider this reluctance to use first names as a way of preventing closeness and desire to maintain formalities.

Family

For the Hispano, the concept of family includes grandparents, uncles, aunts, cousins, godparents and close friends. Hierarchy is of older over younger, and male over female. The head of the family (father or sometimes grandfather) is expected to make decisions (or at least to advise) in situations that affect one of the family members.

Male influence in health matters may be noted in the following. Some men do not like overweight women, either as a sexual ideal or as supportive, maternal figures. But even though they would prefer their wives to be slimmer, they may prevent them from adhering to a weight loss program. Lower body weight may evidence a more attractive individual; self-image may improve as confidence improves with nicer clothes, attractive make-up, better education. All of this may contribute to female assertiveness and independence. The husband's stronghold may be compromised. Attending classes or working outside the home provides more contacts which may be perceived as competition for the wife's attention, and other males may find these women more attractive. An insecure husband therefore, may wish to prevent his wife's physical, psychological or cultural improvement.

However, outside activities are appropriated by the men and encouraged for them. Men may spend time outside with friends, and occasionally, with female company. This is man's nature; it must be tolerated as long as he keeps the wife as the household queen; as long as he is a good provider, as long as he takes care of the children and the children are happy.

A few men, in order to cover their outside activities, may come home and accuse their wives of the very sins they have engaged in. In some cases, this may be carried as far as denial of fatherhood.

Men are often dependant, first on their mothers

and later on their wives. The male offspring are usually discouraged from performing household chores. Therefore, men cannot usually feed themselves or keep a neat, tidy home on their own.

Men are not usually allowed to express emotion. But anger is accepted and may be subtly encouraged in some situations.

Female virginity is still a family property somewhat associated with the family honor, particularly the father's. Parents may come to a physician's office requesting evidence of virginity; virginity may be a requirement to remain in the same household.

Physicians use the time elapsed since the first day of the last menstrual period to determine length of pregnancy. But everyone is aware that implantation usually occurs about the third week of the menstrual cycle. Many times this apparent discrepancy creates anxiety. Some women may fear that their men will consider them unfaithful. This is especially a problem in couples whose travel separations are common.

A mother's personal needs are often considered secondary to the needs of the family. During pregnancy she acquires a special position. She may be placed on a pedestal and receive personal attention and tribute. But often a woman's aspirations and satisfactions are only vicariously realized through her children's achievements and occasionally, her husband's success. Dissatisfaction with this "secondary" role does not prevent women from educating their male offspring in the traditional manner. A frequent source of satisfaction is that, for the children, mother is the most important person on this earth, and is probably second only to God.

Family members gain and maintain respect through their ability to carry responsibilities. Good health is associated with the ability to work, and one resists being incapacitated. Being incapacitated is a misfortune, and may cost the respect of family and friends. Still, each individual represents the whole family. The family helps the sick person and expects the sick person to remain with the family.⁴ This encourages solidarity and the support of the family helps ameliorate feelings of disease. One feels sicker when one is alone. On the other hand, help may be sought outside the family only at great expense of pride and dignity for both the individual and the family.

Folk Medicine

Disease is viewed as a punishment. Good health and prosperity are maintained by delicate

balance of the forces of good and evil. Because of this fatalist conception of life, disease prevention is difficult. Sin and suffering are inevitable, natural occurrences; they cannot be prevented. One can only be cautious and avoid provoking agents, but one cannot prevent disease.

The central core of many Hispano beliefs has existed in Spain for centuries. The similarity and continuity of their present-day beliefs with those that date from before Columbus is striking. Despite the variations in geography, climate, and type of government, some beliefs have remained unchanged, while others have shown a definitive native influence. Some modifications were probably required to adapt these ideas to local environmental variations, including the flora and fauna. These beliefs have a societal function. They allow expression, and offer alternative outlets for many emotions. Early settlers did not have a priest available, so native customs and rituals produced an impact in their celebrations. More recently, folk medicine of other cultures and scientific, modern medical practice have influenced the rationale and therapeutics of Hispano folk medicine.

Many persons feel they may be ridiculed if they admit they believe, or even more if they follow, the dictates of tradition regarding (folk) diseases. Sophistication is synonymous with discarding these ideas or, at least, not acting on them.

Physicians are considered agnostic. Because they lack knowledge, faith and understanding they cannot treat these problems. Most persons agree that traditional diseases will not respond to modern medical treatment. If a traditional disease is not treated promptly, it may be fatal. At a late stage even a specialist in folk medicine (Spanish *curandero*, healer) may be unable to help. Most agree that the *curandero* can recognize diseases that require modern medical treatment and will refer these patients to a physician. *Curanderos* want physicians, in turn, to refer patients afflicted by folk diseases to them, and they complain that physicians do not do so, either because they do not believe in folk diseases or because they do not know how to recognize them.

Growing up among people who believe in folk diseases, one learns to tolerate these beliefs. No benefit is gained by ridiculing them, and an open attitude invites patients to confide. Thus, one becomes familiar with the range of beliefs and therapeutic manipulations. Innocuous folk measures should be allowed or overlooked. If a patient believes that a garlic clove every morning

helps reduce hypertension, the only secondary effect is halitosis. If the rest of the patient's medical regimen is kept there is no danger in allowing the garlic into the therapy. It may even help to improve the patient's trust. When the folk cures chosen are dangerous, at least the physician will have had the opportunity to learn about them.

It is natural to have second thoughts about a certain treatment or a therapist when someone very dear does not improve or even gets worse under our worried observation. It is easy to understand the search for other solutions which may include turning to the old ways recalled from other occasions. If one becomes aware that a patient is being exploited, or prevented from using proven methods of diagnosis and management, then one must take an appropriate stand to speak out strongly.

Folk Diseases

1. *Hot-cold*: The traditional concept of hot versus cold has been preserved intact from the Hippocratic era. Foods and natural agents are considered to have hot or cold qualities independent of observable characteristics such as physical temperature, form, color and texture. The classification as hot or cold describes the effect the agent is thought to produce in the human body. Sometimes too much or too little of an agent is dangerous. The brisk change from one group (hot) to the other (cold) must be avoided or illness will ensue.

2. *Spells (Spanish Brujeria, Embrujo, witchcraft)*: The person under a spell (Spanish *Embrujado*, bewitched) complains of tiredness, insomnia, and restlessness. One only meets sufferers, not the originators of spells. The originators, it is believed, feel that they have been wronged, or their family or property harmed, or they just want to hurt others. Witchcraft may be used to make an individual fall madly in love, to believe the loved object blindly, or to be a slave. The spell may be effected by special workings over a photograph or a representative doll, or it may be effected through food. Smoking while thinking about a desired person forces that person to think of the smoker. The reason for the spell, the type of spell, its originator and other involved persons must be discovered by a *brujo* (witch) and properly antagonized to free the sufferer. The sufferer may then decide to have retribution by means of his own spell, but most just let them go.

3. *Fright (Spanish Susto)*: A person (of any age) may become frightened for one of many

reasons. These include the death of someone close, a natural phenomenon (thunder, lightning), the appearance of a dangerous animal, witnessing a fight, being unable to carry one's responsibilities. The frightened person's soul is taken away or it flies away and the individual appears listless, withdrawn and pale; there is anorexia, and weight loss. An elaborate ritual, usually lasting several sessions, is required to recover the patient's soul. If treatment is not started promptly, *susto* may be fatal.

4. *The Evil Eye (Spanish Mal de ojo)*: This disease caused by a powerful eye is another disease that is fatal if not treated promptly. It usually affects children but may also affect women and domestic animals. The symptoms and signs are similar to those of *Susto*, and in addition, nausea and vomiting may be seen. The originator of this disease may have unwittingly and innocently admired a child, or the beauty of a person or animal and this determined the affliction. At times, envy or ill will can cause the malady. Wearing a red ribbon or red clothes usually protects susceptible individuals from the damaging forces of the evil eye.

5. *Bad air (Spanish Mal aire)* can be an effect of the wind, especially at night when the body is warm, or it can be caused by a cold drink when the body is overheated. Symptoms include back pain, muscle contractions, muscle paralysis. Pneumonia may ensue. *Mal aire* may predispose one to tuberculosis. The treatment involves eliminating the bad air. This may be done by a specialist in rubbing, Spanish *Sobadoras* (masseur), or by a healer plaster, Spanish *ventosas* (cupping). A glass is warmed with a lighted candle to eliminate the air and create a negative pressure or suction, which retains the glass in position for hours, depending on the severity of the affection. This may require more than one treatment session.

6. *Obstruction (Spanish Empacho)*: Ingestion of the wrong type of food can make the walls of the bowels or stomach stick together forming the *empacho* (obstruction) of the intestinal tract. It may happen to persons of any age. Laxatives are the treatment. Laxatives and enemas are also considered prophylactic.

7. *Fallen fontanel (Spanish Caída de la Molera)* can occur in early life. Clinically, it is related to dehydration, the depression of the major fontanel. The treatment is to dangle the child by the legs or to press a finger on the hard palate to "return" the fontanel to its proper level. One wonders about the treatment these infants are getting. There is concern about the appropriate

fontanel tension, as a sign of good health. Early closure of the greater fontanel is considered a cause for concern about physical maturity.

8. *Other Beliefs*: Some common beliefs are similar to those of other ethnic groups. For example, one holds that toxins must be eliminated through menstruation, or sickness will ensue. Absence of menstruation is accompanied by malaise, headaches. A few persons even fear that amenorrhea may lead to cancer. Menstruating women are considered "warm" and must avoid "cold" foods, which may make them sterile. Menstruating women must not pick up a newborn or the child may develop umbilical hernia, and they must not help prepare food or participate in any chores related to reproduction of household animals or the result may be bad.

Spontaneous abortion is associated with sexual intercourse or a frightening experience. Pelvic exam may cause abortion or damage the fetus. The full moon strongly influences some diseases, the incidence of deliveries, the moods of some persons. Male offspring can be conceived under a full moon.

The external genitalia and the breast, must not be shown, or only shown slightly during physical examination. If a woman needs a genital exam, a woman-physician is preferred. Contraceptive agents should be avoided because they are against nature. The message of upbringing that "genitals are dirty" and the "hands off" attitude may instill a lack of interest in pelvic anatomy and physiology. Tampon use is low and a few persons may think they cause cancer.

Tuberculosis is considered to be due to overwork; kidney disease is also considered due to overwork, and especially work involving the back. Repeated episodes of anger can cause liver disease. "Excessive study" may cause brain weakness, brain damage and schizophrenia. Exposure to a shameful situation causes severe headache requiring a special ritual for improvement. Children must not sleep with their parents or other adults. The "humour" of an adult is stronger than that of a child and it can impair the child's development and weaken the child.

9. *Disease of the seven days*. In the past it was common for some children, to suffer an increased muscular tone, hyperreflexia, muscle spasm and death about the seventh day after birth. Blue clothes were thought to afford some protection from this disease. These children were delivered at home, not under sterile conditions. Sterilization of instruments and hospital deliveries have now eliminated the disease, which was probably caused by tetanus spores.

Folk Healers (Spanish Curandero)

Many women, and especially older women, are well informed about the properties and special uses of many folk remedies. Various herbs, roots, feathers, some minerals and wool have particular properties that vary in their effects according to the preparation and time of administration. The modern pharmacopoeia has brought some of these secrets to worldwide attention and use. A healer of either gender is not necessarily a witch, nor associated with dark (evil) forces. More commonly associated with goodness, the healers have specialties. Some claim the favor of favorite saints or other supernatural agents. The lines dividing religion, native beliefs and modern medicine may be vague.

The healers are respected authorities and their methods are familiar and easily understood by "patients" and their relatives. A warm, temporary relationship is established as the healer encourages faith and emanates it. Everyone involved is aware of what is happening and the rationale. This is reinforced, during therapy sessions, when the healer asks the patient and relatives, (especially the important ones), the reason for the consultation and results expected. Success is not promised, but their faith in the healer and rituals is requested to assure success.

Healers know how to make their patients feel better. They are familiar with their patients' activities, problems and associations.

Palm readers also are found in Hispano neighborhoods. They gain their livelihood telling fortunes and giving advice, using many well known psychological techniques, and often taking advantage of the listener's candor.

Modern Alternatives

When they are sick, some persons oscillate between traditional folk methods and modern medical techniques, according to faith in either system. They will choose the system they have the most faith in, the system they understand, that understands them, and puts them at ease; in short, the system that is best qualified in their terms.

Physicians and pharmacists can bridge the gap between the two systems if they have backgrounds similar to the patients or at least are aware of the patient's background. They will be preferred over other practitioners if they can interpret modern disease concepts in the diagnostic and conceptual terminology of traditional folk medicine. Patients will then entrust their worries to the practitioner with whom they may communicate easily and freely, who shows empathy and will not ridicule

any of their peculiar ideas. Sometimes peer or group feeling is important but not essential.

The sick person who considers his illness in the traditional light has the following recourses. (a) Coercion of extrahuman forces by prayers to God, to the Saints to ask for their intercession, by offering special sacrifices, promising to wear a habit (dress), attend religious ceremonies for a specified time, light candles, wear medals or make pilgrimages to specific holy places. The sick person may also ask a witch's intercession or may apply to other evil forces. (b) Use of lay practitioners, including family and friends, use of folk remedies, or of scientific medications without the advice of an attending physician. (c) Use of scientific medical practitioners and their methods and facilities.

Reaction to hospitalization: A sick person requiring hospitalization must deal not only with the illness that determines hospital admission, but also with disruption of daily activities. He has to consider the risk to life hospitalization represents, (i.e., surgery) and the effect of the disease on his future. In addition, the sick person's privacy is threatened by hospital staff and other persons admitted into his private life. He may have to share a room with strangers. He may doubt that he will have time and facilities for his religious practices. Some Hispanos may wonder if they will be isolated. Hospitalization entails a separation from family, and the emotional support of kinship. Likewise, there is a psychological effect on the family that "let go" a member who is ill. Family members and close friends arrive in large groups to visit the sick member and create havoc about hospital regulations. The patient's and family member's understanding of disease etiology and the goals of therapy may differ considerably from those of the physician and hospital staff.

The minimal information available to most health care and other health institution workers should be uniform. Continuing education courses now popular with physicians and nurses may be adapted for other hospital personnel who come in contact with patients (not necessarily only those who participate in the care). Some patients assume that any one who works in a hospital must know medicine. A cleaning lady may give advice in the patient's language and her words have more weight than those of the expert who is not reaching the patient. Dissemination of a minimal amount of uniform knowledge may prevent patients from hearing various opinions from various staff members during the course of their stay in the hospital.

The Need For Translation

A friendly, compassionate attitude can communicate more effectively than technical proficiency in a language. Even when one realizes the patient cannot understand our words, the inflexion of our voice, our gestures, hand movements, facial expression and intensity of our eyes do communicate. They provide comfort and reassurance, and demonstrate our concern for the human being before us. A staff worker who has recently risen above his low socioeconomic group may be disdainful of the plight of his uneducated countryman, and create antagonism and a communication block. When translators must interpret to both parties, some details are inevitably lost. Translators must be carefully chosen. ◀

References

1. Kilian M.: *Chicago Tribune*, Editorial page, Dec. 27, 1977.
2. *Diccionario de la Lengua Espanola. Real Academia Espanola, XIX Ed., Esposa-Calpe, S.A.* Madrid, Spain, 1970.
3. *THE NEW ENCYCLOPAEDIA BRITANNICA*. 15th Ed. Vol. 17, page 381, William Benton, Pub, Chicago 1973.
4. Edgerton R.B., Karno M.: "Mexican-American Bilingualism and Perception of Mental Illness," *Arch. Gen. Psychiat.*, 24:286-290, March 1971.

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Student Contributions

The Superior Vena Cava Syndrome

A review of the literature

BY JOHN HOUSER, M.D./CHICAGO

The literature of the past fifteen years has been researched for this review of the Superior Vena Cava Syndrome. There is much debate as to whether or not invasive procedures should be used in diagnostic efforts and how much they affect the quality of patient care. The treatment plan of choice has changed in important ways recently. Present day views of these aspects are considered. Etiologies, anatomical and pathophysiological considerations, signs and symptoms, and prognosis are also presented because of their importance to the practicing clinician.

The Superior Vena Cava Syndrome (SVCS) was first reported in 1757 by William Hunter as a complication of an aortic aneurysm secondary to syphilis. Classical SVCS is an obstruction of the superior vena cava, but traditionally, the SVCS can refer to an obstruction of one or more of any of the central systemic veins. The manifestations of the syndrome are secondary to the high venous pressure "upstream" from the obstruction and include venous dilation, plethora, and edema to name a few. This review of the literature pertaining to the SVCS deals with etiology, anatomical and pathophysiological considerations, signs and symptoms, various schools of thought concerning diagnostic procedures, the past and present treatment and management methods of choice, and prognosis of recurrence and lifespan.

Etiologies

Neoplasm is responsible in up to 97% of SVCS cases in some series. Bronchogenic carci-

noma is the most common offender causing 75%, lymphoma causing 15%, and metastatic cancer causing 7%.¹ Histologically, some authors² claim squamous cell type is the leading cause. Others claim undifferentiated small cell or oatcell,³⁻⁵ while some believe that there is a fair representation of the various forms of bronchogenic carcinoma.⁶ Other malignant etiologies of SVCS include histologic types of lung cancer, mediastinal fibrosarcoma, Hodgkins Disease, metastatic cancer from the breast, thyroid, or pancreas, and "unknown" malignancies.^{4,7} Along with the malignant causes, there are many benign causes of SVCS that have been reported.^{1,2,8,10-12,14} (Table 1)

Anatomical Considerations and Pathophysiology

The superior vena cava is the major blood return line from the head, neck, arms, and upper thorax. Unfortunately, it is particularly vulnerable to obstruction because of the following: (1) it is thin walled and part of a low pressure system; (2) it, along with the Azygos (the main collateral), is surrounded by lymph node chains that drain all the structures of the right thoracic cavity and the lower left; (3) it is juxtapositional to the right mainstem bronchus and is therefore close to expanding bronchogenic tumors; and (4) it is locked in a tight compartment of the mediastinum and sternum.⁴⁻¹³ The above facts account in part for the fact that the SVCS is four times more common with tumors of the right lung than those of the left.^{1,4,13} This also help to explain

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TABLE 1
Benign Etiologies of SVCS

- I. Mediastinitis**
 - A. Tuberculosis
 - B. Histoplasmosis
 - C. Actinomycosis
 - D. Syphilis
 - E. Pyogenic
 - F. Post-radiation
 - G. Idiopathic
- II. Mediastinal Tumors**
 - A. Cystic hygroma
 - B. Substernal thyroid goiter
 - C. Benign teratoma
 - D. Dermoid cyst
 - E. "Benign" mediastinal thymoma
- III. Vascular**
 - A. Aortic aneurysm
 - B. AV fistula
 - C. Surgery involving the superior vena cava
 - D. Dissecting aortic aneurysm
 - E. Vasculitis
 - F. Congenital superior vena cava aneurysm
 - G. Bilateral superior vena cava with thrombosis
 - H. Idiopathic thrombophlebitis with thrombosis
 - I. Thrombosis accompanying polycythemia
 - J. Aortitis
- IV. Cardiac**
 - A. Atrial myxoma
 - B. Intrapericardial band
 - C. Pericarditis
 - D. Mitral stenosis
 - E. Surgical bypass in congenital heart disease
 - F. Complication of ventriculo-atrial shunts
 - G. Complication of transvenous cardiac pacemaker
 - H. Pericardial constriction
- V. Pulmonary**
 - A. Mediastinal emphysema
 - B. Pneumothorax
- VI. Traumatic**
 - A. Mediastinal hematoma
- VII. Other causes**
 - A. Behcet's syndrome
 - B. Retroperitoneal fluid
 - C. Bilateral clavicular osteomyelitis
 - D. Silicosis
 - E. Sarcoidosis

Recently, Wilson¹⁴ described an additional pathway through the pulmonary veins. This, however, is a very rare occurrence and seems related to anastomoses within pleural adhesions.

Signs and Symptoms

With an appreciation of the anatomical and pathophysiological considerations, it is easy to understand the resulting signs and symptoms; these are secondary to venous obstruction and the resultant increased venous pressure distal to the obstruction.

This syndrome usually has an insidious onset^{1,13} although some of the more rapidly expanding etiologies can stimulate a rapid onset of symptoms.^{3,11,15} The following signs and symptoms of SVCS have been reported in the literature: (1) dilatation of the internal collateral vessels; (2) dilatation of the external veins of the head, neck, arms, upper torso, and breasts; (3) edema and plethora of the face, neck, arms, upper torso, and breasts; (4) venous hypertension of the upper body; (5) conjunctival edema; (6) CNS symptoms such as headache, somnolence, visual distortion, nausea, dizziness, syncope; (7) bronchial constriction leading to respiratory distress, dyspnea, cough; (8) pleural effusion, chylothorax; (9) esophageal edema leading to dysphagia, choking; (10) cyanosis and (11) inability or discomfort to lie flat or to stoop.

Obviously, it would be unusual for a patient to present with all or even most of the above; those symptoms and signs which do present are determined by the exact spot of the obstruction(s) and the availability and development of collaterals, which in turn depends on the rate of onset of the obstruction.

Diagnostic Procedures

There has been great debate over recent years as to whether or not diagnostic procedures are called for and to what extent they help or affect the quality of patient care. Lokich and Goodman¹ write: "the pitfalls in the management of SVCS relate to overzealous efforts to establish the site of obstruction and to determine a specific histopathologic diagnosis. These efforts include venography, venous pressure manometry, esophagoscopy, bronchoscopy, cervical mediastinal exploration, and upper extremity venipuncture or injection. They may lead to life threatening complications, such as respiratory obstruction, aspiration, and hemorrhage."

They maintain that the diagnosis of SVCS is a

why obstruction above the Azygos is better tolerated than when below⁴ and why slowly expanding etiologies are better tolerated than rapidly expanding ones.

In any case, once obstruction has occurred, collateral pathways compensate by dilatation and increasing flow. There are four generally accepted collaterals that develop unless they, too, are obstructed. These are (1) the Internal Mammary pathway; (2) the Azygos pathway; (3) the Lateral Thoracic pathway and (4) the Vertebral pathway.

clinical one and therefore does not require such techniques for diagnosis. Further, they hold that venous access procedures may induce hemorrhage due to the increased pressure. Invasive diagnostic procedures should be postponed until the acute situation has been relieved, to avoid possible respiratory compromise and/or hemorrhage when carried out in edematous tissue in the area of dilated collateral vessels.¹

There is some opinion, however, that venography is relatively safe and easy,¹⁶ that it can yield valuable information to confirm a possibly doubtful diagnosis, help in the decision concerning the value of anti-coagulants, influence radiation techniques and field, and give prognostic data concerning the probable efficacy of radiation treatment.¹⁷

Lokich and Goodman¹ hold fast that treatment is not determined by venography in most cases and that, even though it may be done safely in most patients, its risks outweigh its benefits.

Treatment

Since 97% of the cases of SVCS are caused by neoplasm, the following discussion will consider the treatment in only those cases. An excellent review of treatment for benign SVCS has been done by Mahajan.¹⁸

Much has changed over the years concerning treatment of SVCS. There are now four basic therapeutic modalities, with high-dose-short-interval radiation the mainstay around which diuretics, steroids, and anti-coagulants are added as adjuvants.

The formerly accepted mode of treatment was to initiate nitrogen mustard or low-dose-long-interval radiation which was followed by high-dose-short-interval radiation a few days later. The nitrogen mustard was used to bring about rapid initial regression while avoiding "radiation edema," after which high-dose-short-interval radiation could be safely and effectively used.^{7,15}

On the other hand, it has now been reported that the progressive edema seen with the initiation of low-dose-long-interval radiation is due to tumor progression secondary to ineffective therapy rather than "radiation edema" and that patients started on high-dose-short-interval radiation tolerate the therapy very well.²⁰ In a randomized study, Levitt has found that there is no apparent advantage to the use of nitrogen mustard prior to the initiation of radiotherapy. He concluded that in light of the side effects of the nitrogen mustard, "the use of the initially high daily dose radiation technique . . . would be pre-

ferable. In those few patients who absolutely cannot be brought to the X-ray therapy department, nitrogen mustard can be an effective palliative agent and should be used despite the complications."²¹

High-dose-short-interval radiation is now considered by most to be the mainstay treatment of choice. The extent of the disease determines the field with local disease getting small field radiation and disseminated disease getting large field radiation.^{1,5,13} Obviously, treatment in SVCS caused by malignancies is only palliative.

It should be added at this point that a recent study by Kane³ shows good results using chemotherapy as a treatment for SVCS caused by oat-cell carcinoma. This treatment should be kept in mind but regarded with reserve until more investigation is done.

Although surgery offers the benefits of both removing the obstruction and providing a histological diagnosis, the morbidity and mortality incidence is great. Although some may argue,²² it is widely held that surgery has only an exceptional place at best in the treatment of SVCS.^{1,7}

Diuretics are employed for symptomatic relief, are effective early in the course of the disease^{1,20} and are considered to be the best adjuvant to radiotherapy.¹³ The effects are likely to be transitory and care must be taken to avoid dehydration which would increase stasis and potentiate the tendency toward thrombus formation.

Because of the frequent presence of thrombus formation in SVCS, anti-coagulants have been employed and are especially helpful in rapidly progressive disease. It has been reported that anti-coagulants and fibrinolytics help preserve the collateral circulation and prolong survival.^{1,5}

Steroids have been used to alleviate inflammation that is presumably due to radiation. Although their value is controversial, it is suggested that they be used, especially in cases where respiratory compromise is present.¹

Prognosis

According to Howard,¹⁷ in the case of SVCS with a malignant cause, neither the duration of the obstruction, the histological type of tumor nor the severity of the obstruction seems to have any prognostic value pertaining to recurrence of the SVCS; this prognosis depends only on the radiation dosage and the availability of collateral circulation. With doses greater than 3000r., recurrence appears to be the least likely.

The life span prognosis, however, is basically the prognosis of the underlying disease. In those

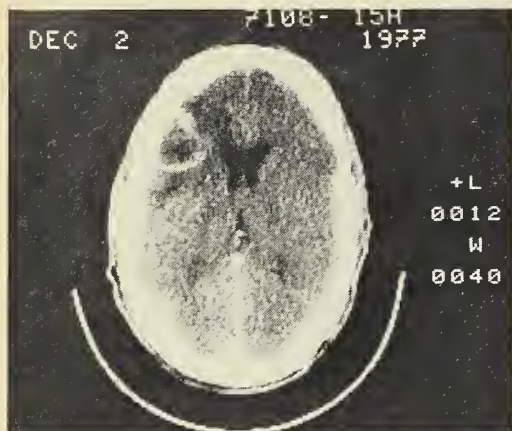
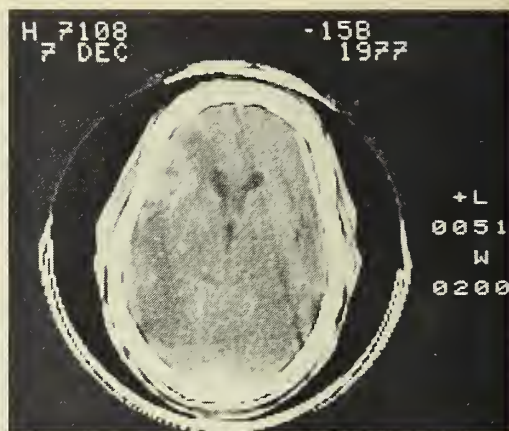


Figure 1 (Left) Post-infusion CT scan showing left frontal mass and no midline shift of the ventricular system. Figure 2 (Right) shows Post-infusion CT scan showing the increased size of the left frontal mass of increased radiodensity surrounded by a zone of decreased density or edema.



transfer to our hospital he developed an expressive aphasia. At the time of admission he was lethargic and disoriented to time, person, and place. Neurological examination disclosed no papilledema, but he did have three flame hemorrhages in his left retina. A CT scan showed a large ring-like lesion in the left frontal lobe with no shift of the midline intracranial structures (Figure 1). The patient was started on intravenous Tobramycin and Ticarcillin, and he became more alert and oriented. Cerebral angiography confirmed the left frontal lesion. A repeat CT scan showed that the lesion was larger and it disclosed evidence of a slight midline shift of the ventricular system from left to right (Figure 2). A left frontal craniotomy was performed one week after admission. Upon opening the dura, the brain had a xanthochromic color. Using a ventricular cannula an abscess was cannulated. Most of the capsule of the abscess, which was adherent to the branches of the left middle cerebral artery, was removed piecemeal. Cultures of the necrotic purulent material of the abscess cavity were negative. Twelve days later, he underwent thoracic surgery for an aortic valve replacement. Intraoperative cultures from vegetations on the aortic valve reported *Pseudomonas aeruginosa*. Postoperatively he was treated on a four week regimen of the same intravenous antibiotics. A

postoperative CT scan disclosed no evidence of a mass lesion in the left frontal lobe. The pathological report disclosed chronic cerebral inflammation consistent with a diagnosis of chronic cerebral abscess.

Discussion

In 1969 Jones stated that 20% of a group of 385 patients with bacterial endocarditis had neurological involvement.⁵ In 60% of these 110 patients with neurological findings, the neurological complaint was either the chief complaint or one of the major presenting complaints.⁵ Cerebrovascular lesions, arteritis, and transient ischemic attacks constituted about 80% of the neurological complications.^{5,10} However, heroin addiction was present as an etiological factor in only three patients with bacterial endocarditis.⁵⁻¹⁰ In 1939, Kernohan reported that in heroin addicts with endocarditis, mycotic aneurysms, commonly occurring in the distal portion of the middle cerebral artery, are much more common than meningitis or brain abscess.^{4,10} They are frequently associated with rupture into the subarachnoid space and the brain parenchyma.⁴⁻¹⁰

Few heroin addicts have had documented brain abscesses.^{1,5,9,10} Karandanis, in 1975, described one patient who was a polydrug abuser, and who had multiple fungal

abscesses (*Caldosporium*) in his brain at autopsy.⁹ Earlier, Kernohan found one heroin addicted patient with multiple cerebral abscesses at autopsy.¹⁰ His patient also had a septic bacterial endocarditis with *Streptococcus viridans* as the causative agent.¹⁰ In 1977, Amine presented two heroin addicted patients with brain abscesses, the abscess of one patient being associated with a mycotic aneurysm.¹ The etiological agent of the patient with both brain abscess and mycotic aneurysm was *Staphylococcus aureus* (coagulase positive).¹ The other patient who had a large encapsulated right frontal abscess underwent a complete removal at operation and he survived.¹ The bacteria from anaerobic cultures of the abscess was *Streptococcus viridans*.¹ Our heroin-addicted patient had a successful extirpation of a large frontal abscess. While his cultures did not grow out any bacteria, cultures that were later taken from vegetations on the aortic valve grew *Pseudomonas aeruginosa*.

Infectious neurological complications in heroin addiction are attributed to subacute bacterial endocarditis and septic emboli, bacteremia, and/or altered immunological mechanism.^{1,5,7,10} While the actual pathophysiological mechanism for development of the brain abscess in our patient is unknown, the fact remains that he did have positive cultures from the

blood and from vegetations on the aortic valve. The commonest of offending organisms in neurological complications of narcotic addiction are *Staphylococcus aureus*, hemolytic *Streptococci*, rare fungi, and *Candida*.^{1,5,7,10} *Pseudomonas aeruginosa* has been recently implicated in chondro-osteomyelitis and cervical diskitis in drug-addicted patients,² as well as the causative organism of many recent cases of bacterial endocarditis.^{4,5} While the accumulated evidence for the development of brain abscesses in heroin addicts indicates that the infection is bloodborne, the addict's altered immunological mechanism could explain the development of brain abscesses by fungi and other normally nonvirulent bacteria.^{5,6,7}

Successful surgical extirpation of our patient's abscess and his survival are basically due to the early diagnosis and treatment before rupture and development of coma,⁹

and to the technical capability of CT scanning. ◀

References

1. Amine, A.: "Neurological Complications in Heroin Addiction: Brain Abscess and Mycotic Aneurysm," *Surg. Neurol.*, 6:483-484, 1977.
2. Byran, V., Franks, L., Torres, W.: "Pseudomonas Aeruginosa Cervical Diskitis with Chondro-Osteomyelitis in an Intravenous Drug Abuser," *Surg. Neurol.*, 1:142-144, 1973.
3. Challenger, Y.B., Richter, R., Brunn, B., Pearson, J.: "Nontraumatic Plexitis and Heroin Addiction," *JAMA*, 225:958-961, 1973.
4. Gilroy, J., Lourdes, A., and Thomas, V.J.: "Intracranial Mycotic Aneurysms and Subacute Bacterial Endocarditis in Heroin Addiction," *Neurology* (Minneapolis), 73:1193-1198, 1973.
5. Jones, H.R., Siekart, R.G., and Geraci, J.E.: "Neurologic Manifestations of Bacterial Endocarditis," *Ann. Intern. Med.*, 71:21-28, 1969.
6. McLone, D.G. and Siqueira, E.B.: "Postmeningitic Hydrocephalus and Syringomyelia Treated with a Ventriculoperitoneal Shunt," *Surg. Neurol.*, 6:323-325, 1976.
7. Richter, R.W., Pearson, J., Brunn, B., Challenor, Y.B., Brust, J.C. and Baden, M.M.: "Neurological Complications of Addiction to Heroin," *Bull. N.Y. Acad. Med.*, 49:3-21, 1973.
8. Smith, R. and Wilson, A.: "Guillain-Barré Syndrome in Heroin Addiction," *JAMA*, 231:1367-1368, 1975.
9. Karandanis, D. and Shulman, J.: "Factors Associated with Mortality in Brain Abscess," *Arch. Intern. Med.*, 135:1145-1150, 1975.
10. Kernohan, J.W., Wolftmun, H.W., and Barnes, A.R.: "Involvement of the Nervous System Associated with Endocarditis," *Arch. Neurol. Psychiat.*, 42:789-804, 1939.

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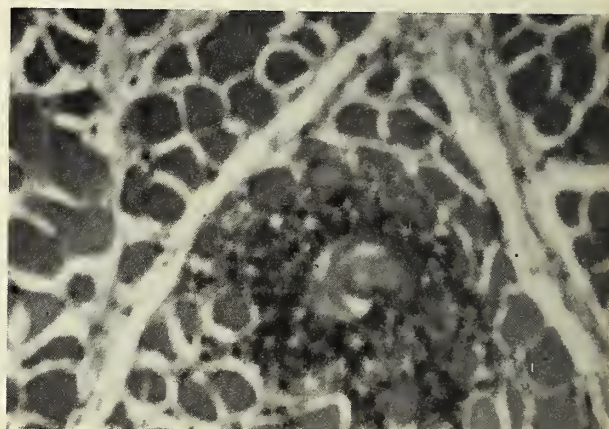
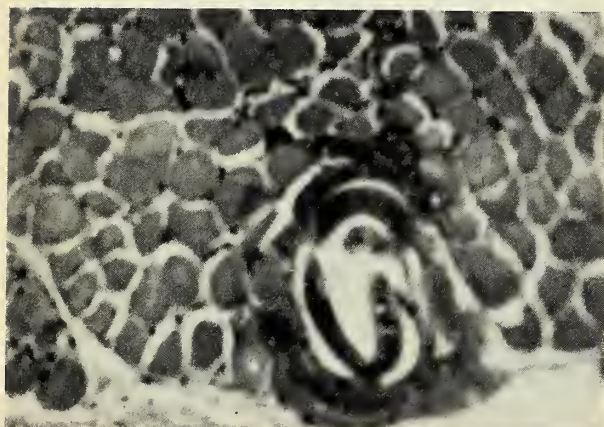


Case Report and Discussion

Trichinosis

BY JOHN L. BENDER, M.D., AND DONG C. HUH, M.D./ROCKFORD AND WOODSTOCK

The authors present a case report of a woman who, after ingesting raw pork sausage, presented with classical symptoms of trichinosis. These included central nervous system signs of brachial monoparesis. Diagnosis was confirmed by muscle biopsy and treatment consisted of prednisone and thiabendazole.



Figures 1 A and B

Examples of *Trichinella spiralis* found in right deltoid muscle. (H and E stain). Courtesy of F.A. Elmudesi, M.D.

In 1835, James Paget first described the condition known as trichinosis. This parasitic infestation is world wide, with the exception of Australia and the Pacific Islands. Each year in the United States, one hundred clinical cases and two deaths are attributed to trichinosis.¹⁻²

Case Report

A 39-year-old woman was admitted with a ten-day history of persistent fever running as high as

39°C. She also had orbital and facial edema, nausea, anorexia, headache, tenderness and weakness of both arms and incoordination of the right hand and arm. Since her early years in Europe, she had been in the habit of consuming raw beef and pork. One week prior to the onset of her symptoms, she had eaten raw pork sausage. An outpatient CBC revealed an eosinophil count of 25%.

When admitted to the hospital, her vital signs were B.P. 132/68, temperature 37.5° C, pulse 104/

min., respirations 24/min. The edema had cleared. There was a grade 1/6 aortic systolic murmur. Orientation, speech and cranial nerves were normal. The patient had a spastic right brachial monoparesis with accompanying incoordination. When walking, she tended to drift toward the right. Tendon reflexes of the right arm were abnormally brisk; all other reflexes and her sensory examination were normal.

Laboratory data: CBC, Hbg 10.8 Gm%, Htct 33%, 3.52 million RBCs, 9,200 WBCs; differential 50 segmented neutrophils, 19 lymphocytes, 3 monocytes, 28 eosinophils. RPR nonreactive. Urinalysis 18-20 WBC/HPF. SED rate 26 mm/hr. Blood chemical screening normal except for protein 5.2 Gm%, albumen 2.6 Gm%, calcium 8.2 mg%, LDH 334 I.U., SGPT 51 I.U., CPK 165 I.U. Electrolytes, prothrombin time, ANA, febrile agglutinins, CRP, AST, stools for

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ova and parasites and toxoplasmosis titer were normal. Immunoglobulins A and M were slightly elevated. EKG revealed only non-specific S-T and T wave changes. Chest and skull X-rays and isotope brain scan were normal. EEG showed transient 1-3 Hertz activity in both anterior hemispheres. Repeat blood count 8, 12 and 15 days later showed 27%, 27% and 17% eosinophils respectively. Lumbar puncture: O.P. 220mm of water with clear, colorless fluid. CSF 128 RBCs/mm, no WBCs and normal chemistries. Biopsy of the right deltoid muscle revealed destruction of muscle fibers, mononuclear cell infiltrate and encysted larvae compatible with *Trichinella spiralis*. (See Figure 1.)

The patient was treated with prednisone, 60 mg., every other day and thiabendazole, 1.25 Gm. B.I.D. Within 24 hours, her head-

aches had disappeared. Her neurological status was normal within five days. She was dismissed 17 days after admission and has remained asymptomatic.

Discussion

Present estimates indicate that 4.4 million people in the United States have been infected with trichinella and 150-300,000 new human contacts occur each year.¹ Diagnosis depends on a history of consuming inadequately cooked meat. Fever, orbital and facial edema and rash occur early. Muscular invasion results in myalgia and flaccid paralysis.³ Between 10 and 25% of all clinical cases involve the central nervous system, either as a nonspecific meningismus with good prognosis or, as in our case, a more severe focal meningoencephalitis.⁴

Death occurs because of CNS complications or myocardial failure in the fourth to eighth week of illness. Treatment in humans is with benzimidazoles, piperazines and adrenal steroids.⁵ ◀

References

1. Steele J.H., Arambulo P.V.: "Trichinosis—A World Problem with Extensive Sylvatic Reservoirs," *Int. J. Zoon.* 2:55-75, 1975.
2. Grove D.I., Warren K.S., Mahmoud A.A.: "Algorithms in the Diagnosis and Management of Exotic Diseases, VII Trichinosis," *J. Infect. Dis.* 132:485-488, 1975.
3. Aita J.F.: "Diagnosis of Trichinosis," *Nebraska MJ*: 344-346, Sept. 1974.
4. Spaeth G.L., Adams R.E., Soffe A.M.: "Treatment of Trichinosis," *Arch. Ophthalmol.* 71:359-363, 1964.
5. Campbell W.C., Blair L.S.: "Chemotherapy of *Trichinella spiralis* Infections (A Review)," *Exp. Parasit.* 35:304-334, 1974.

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(Continued from page 440)

Answers: 1.E 2. E

The ECG rhythm strip shows atrial fibrillation in the first six beats with an irregular but controlled ventricular response at approximately 80 beats/minute. The attempt to perform D.C. cardioversion at 200 watt-seconds failed but the 300 watt-second countershock caused two ventricular escape beats followed by sinus rhythm. The P wave was distorted initially and could not be differentiated from a coronary sinus rhythm. The bottom strip shows the development of premature atrial beats in bigeminy. The sixth, eighth, tenth, and twelfth beats in the bottom strip are premature atrial beats. At first, it appeared that the 300 watt-second countershock had converted atrial fibrillation to a coronary sinus or ectopic atrial rhythm. This would suggest that the sinus node pacemakers were not normal. However, the P wave distortion was most likely related to our ECG lead selection, the D.C. cardioversion itself, and possibly quinidine. Both digoxin and quinidine were used initially in an attempt to restore sinus rhythm. The digoxin was discontinued four days prior to the D.C. cardioversion. Although no data exists for surgery on atrial myxomas, postoperative atrial fibrillation is very common following mitral valve surgery. The development of atrial fibrillation following open heart surgery carries a better prognosis for continued maintenance of sinus rhythm than some other presentations of atrial fibrillation. Success in cardioversion of atrial fibrillation to normal sinus rhythm is related to left atrial pressure and volume as well as the underlying pathology. D.C. cardioversion usually restores good atrial contractility. Our patient was taken off all cardiac medications and has remained asymptomatic. ◀

Responsibilities To Provide Access To Handicapped People

If you provide services to Medicaid patients, participate in a Health Maintenance Organization or Individual Practice Association that contracts with the Department of Public Aid, or operate a clinic, group practice or business that receives federal funds, you are obliged under federal law to provide access to employment opportunities and services to handicapped people in your community. The information contained in this article is intended to define who must provide access, who is considered handicapped, and how compliance may be achieved.

Section 504 is a part of the Rehabilitation Act of 1973. This section applies to individuals, institutions and agencies receiving or benefiting from federal financial assistance. It requires that equal opportunity in employment and equal opportunity to participate in programs and services be extended to handicapped people.

Each federal agency is responsible for issuing regulations that specify how recipients of its funds are to comply with the law. In May of 1977, the Department of Health, Education, and Welfare issued its regulations. These regulations cover any individual or group that receives or benefits from HEW funds, including Medicaid and Medicare Part A.

The Office for Civil Rights (OCR) in HEW is responsible for enforcing Section 504. All federal agencies will be issuing regulations consistent with the standards and procedures developed by HEW. The OCR office in Chicago will be the channel for complaints, grievances, and compliance questions in this region.

Who Must Comply With Section 504?

Any individual, program, facility or agency receiving federal financial assistance through grants, loans, or contracts (except for procurement contracts and contracts of insurance or guarantee) is considered a "recipient" and, therefore, obliged to comply with the law. Health care recipients include individuals, such as physicians, and facilities that receive Medicaid funds. Part A of Medicare is also considered federal financial assistance. However, medical providers receiving only Medicare Part B funds are *not* governed by Section 504. If an HMO contracts with the Department of Public Aid to provide services to Medicaid patients, all medical providers participating in that HMO are governed by Section 504.

The regulations make frequent distinctions between large recipients, with 15 or more employees, and small recipients, who employ fewer than 15 employees. The purpose of the distinction is to accommodate those recipients for whom

major compliance efforts might represent an undue administrative or financial burden. Specifically, the regulations provide that:

- In the area of program accessibility, small providers may, after consultation with the handicapped person seeking services, refer the person to an accessible provider if meeting accessibility requirements would mean a significant alteration in existing facilities and the referring recipient has determined that the other recipient is willing to accept the referral and is accessible;
- In the area of auxiliary aids to permit handicapped people to utilize a service, small providers need not provide such aids if doing so would significantly impair their ability to provide services; and
- In the area of compliance procedures and paperwork, small providers have less complex and more flexible requirements.

Who Is Considered "Handicapped"?

Under the Section 504 regulations, a "handicapped person" is one who:

- Has a physical or mental impairment that limits one or more of the person's major life activities;
- Has a record of such an impairment; or
- Is regarded by others as having such an impairment.

Major life activities are such functions as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Alcohol and drug dependent persons are considered handicapped under this definition.

General Compliance Procedures

Assurances—Recipients are required to prepare formal statements offering assurance that their programs will be operated in compliance with Section 504 and to submit these assurances

to the federal agency from which their funds originate. In the case of Medicaid providers, signing the certification on the bottom of the billing form constitutes the assurance.

Self-Evaluation—Recipients are required to complete a self-evaluation and, if structural or program barriers to the participation of handicapped people are identified, to write a plan specifying how the policies, facilities, and/or services will be modified to make them nondiscriminatory. Handicapped people and/or organizations representing handicapped people, are to participate in the development of this master plan.

Compliance Effort and Grievance Procedure Coordination—Large recipients, *i.e.*, those with 15 or more employees, must appoint a person to coordinate their efforts to comply with the Section 504 regulations. They must also adopt grievance procedures for persons wishing to file complaints of discrimination.

Notification of Nondiscrimination—Large recipients must take steps to notify employees, participants and candidates for employment or services that their policies and procedures are nondiscriminatory. "Nondiscriminatory" means that:

- A job applicant is judged on the basis of his or her individual abilities and qualifications to perform the essential functions of the job in question;
- A handicapped applicant is offered reasonable accommodations to enable him or her to perform the job;
- The recipient provides auxiliary aids, such as brailers and interpreters, to allow handicapped people to utilize its services; and
- The services for handicapped people are not unnecessarily separate or different from those provided to others.

Employment

No qualified handicapped person may be discriminated against in employment on the basis of his or her handicap. To comply with this provision, a recipient must first define the specific essential functions of a job. On a case by case basis, a recipient must then determine what reasonable accommodations can be made to permit a handicapped applicant to perform these functions. Examples of reasonable accommoda-

tions include making the facilities used by employees accessible, restructuring the job, changing the work schedule, modifying equipment, and providing auxiliary aids, such as a reader or interpreter.

A recipient need not make reasonable accommodations if they would cause an undue hardship because of the cost involved or the administrative burden. There will also be no finding of discrimination if a handicapped applicant is rejected because he or she would not be able to perform the essential job functions even with reasonable accommodations.

Pre-employment questionnaires and tests must be based on a person's qualifications and abilities to perform the job, and their results must reflect these alone. Furthermore, pre-employment medical examinations may not be required or pre-employment inquiries made in order to determine the existence, nature, or severity of a handicap.

Program Accessibility

A recipient may not discriminate against the handicapped by housing its programs in facilities that cannot be accessed or used by handicapped people. Facilities include buildings, equipment, parking lots, roads, walks, and other real or personal property.

Programs are to be viewed in their entirety. The regulations do *not* require that each facility or every part of a facility operated by the recipient be accessible to handicapped people. Rather, they require that handicapped people have an opportunity to participate in the recipient's services or programs. Recipients may comply either by using alternate sites, removing barriers, assigning aides to the person, or offering programs in the individual's home. Structural changes are required *only* where no other feasible solution exists.

If structural changes are needed, the recipient must create a Transition Plan describing the modifications and the timetable for completing them. HEW requires such changes to be accomplished by June, 1980. Facilities constructed or modified after the effective date of the regulations (May 4, 1977) must be accessible.

Again, recipients with fewer than fifteen employees may refer handicapped participants to another provider who is accessible.

Service Delivery

Section 504 regulations prohibit discrimination in delivery of health, welfare and social services.

These regulations cover handicapped people who meet eligibility criteria for receipt of services. They provide that these qualified handicapped persons must receive services as effective as those provided to others. Services offered handicapped persons must not be different or separate unless they cannot otherwise be as effective.

Services must not be provided in a manner that limits the participation of handicapped people. Moreover, recipients must provide auxiliary aids so that people with sensory, manual, or speaking impairments can participate. The aids may include interpreters, writing pads, flash cards, or other items that permit communication between the service provider and the patient or client.

Recipients with fewer than fifteen employees are permitted to refer patients if they cannot provide an accessible service. They need not provide auxiliary aids if to do so would significantly impair their ability to provide services.

Should you require further information about the regulations, contact Larry Boress, Division of Medical Services, Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603. ◀

Next Month in IMJ

Neonatal Respiratory Distress Syndrome in Illinois: Report of a Study

Pemphigus and Bullous Pemphigoid: Seminars in Immunopathology and Oncology

Summary of Actions, 1979 Interim Session, ISMS House of Delegates

Viewbox

(Continued from page 442)

DIAGNOSIS: Chron Disease

Diffuse superficial ulceration suggests pancolitis. The ulcers are seen as discrete normal collections of barium (arrows, Figure 2) with a surrounding halo. They vary from one to several millimeters and are seen on a background of normal mucosa.

These "aphthoid" ulcers are among the earliest changes of Chron disease.¹ They have not been identified in ulcerative colitis. Demonstration by conventional barium enema is extremely unlikely and stresses the need for double contrast radiography in detection of early changes in inflammatory bowel disease.

These ulcers have similar appearance in other

portions of the G.I. tract. Involvement of the stomach and duodenum in 20-40% of patients with Chron disease in the terminal ileum and colon is of interest.² Although these ulcers may disappear with appropriate treatment, recurrent disease is common.

Other conditions in which aphthous ulcers are seen include Amoebic colitis, Behcet's syndrome and certain bacterial enterocolitis.

1. Kelvin, F., *et al*: "Double Contrast Barium Enema in Chron's Disease and Ulcerative Colitis," *Am. J. Roent.*, 131:204-213, August, 1978.
2. Laufer, I.: *DOUBLE CONTRAST GASTROINTESTINAL RADIOLOGY*, W.B. Sanders, 1979.

Report of Joint Practice Survey

Illinois Joint Practice Committee

By JEAN DOMER, R.N., M.S.N. and FRED Z. WHITE, M.D., Co-Chairpersons

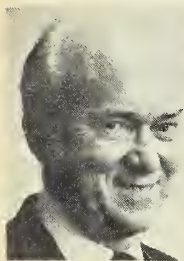
The Illinois Joint Practice Committee convened its first meeting in 1973. It is composed of eight members, four practicing physicians and four practicing registered nurses.

Joint practice is defined by the National Joint Practice Commission as: "nurses and physicians collaborating as colleagues to provide patient care." One committee goal is to promote joint practice by encouraging formation of joint practice committees in hospitals, ambulatory and mental health centers.

Although the Joint Practice Committee has long discussed joint practice in concept and had looked at some existing joint practice arrangements, little was known about activities in our Illinois hospitals.

Before embarking on any educational program or attempting to further implement this concept, we wanted to know the existing attitudes and needs as expressed by the hospitals and their medical and nursing staff. To that end a survey was constructed and mailed to the 284 Illinois hospitals.

Of the 111 responses, 31 (27.9%) reported some structural unit addressing nursing and medical practice; 78 (70.3%) had none and 2 (1.8%) did not respond to the question. The



FRED Z. WHITE, M.D., ISMS first vice president, is a board certified family practitioner and fellow of the American Academy of Family Physicians. Associate director for the department of family practice at Methodist Medical Center of Illinois and an associate professor on the faculty of the Peoria School of Medicine, Dr. White has held a wide range of appointive and elective posts in clinical and academic medicine, as well as local and statewide medical society activities.

A member of the Illinois Joint Practice Committee, Dr. White was co-chairperson of this writing.

JEAN DOMER, B.S.N., M.S.N., is a clinical nurse specialist in medical nursing at Loyola University's Foster G. McGow Memorial Hospital, where she also serves as an assistant clinical professor in the School of Nursing. A member of the Illinois Joint Practice Committee, she was a co-chairperson at this writing.

most frequent description (11) of this structure was an administrative committee made up of department heads to deal with problems (Patient Care Committee, Coordinating Committee for Patients). Seven cited joint audits as their form of joint practice. Four cited directors of nursing sitting in on medical staff meetings and four mentioned nursing representation on medical and administrative committees. Four had structures that seemed to meet the definition of joint practice—one at an administrative level, one at an HMO, and two at a nursing unit level—one patient care conferences, and one for ICU-CCU policy and procedure and patient care. This data points to the broad and/or confused interpretation of "joint practice."

Of the 31 hospitals reporting some sort of joint practice structure, eight (25%) reported 12 types of nurse expanded role titles—they were nurse practitioner, clinical nurse specialist, UR coordinator, stoma therapist, infection control, director of nursing, pediatric nurse associate, liaison nurse, non-M.D. surgical assistant, etc. All but the non-M.D. surgical assistant and the health care assistant were employed by the hospital, including the nurse practitioners. (23 of the 30 did not indicate using expanded role titles.)

The survey did ask for a description of function and composition of the committee that institutions perceived as filling the role of a joint practice committee. A review of this description showed that nine of these appeared to function more as management or professional affairs committees. These were composed of administrative heads, staff, department chairmen and the director of nursing. Other professionals were occasionally included.

In the second most frequent model, (eight hospitals) the committee performed a liaison function. Here the director of nursing observed or sat on active staff committees or departmental meetings.

Five respondents described an MCE Study and/or Audit Committee function. This seemed

to represent an active staff activity with representation from nursing administration and other strata of the institution.

Four of the responders had committees that seemed to meet the definition of a joint practice committee. These committees were composed of staff nurses with or without administrative nursing heads and active medical staff participation. Some had added administration input and/or input from other professional strata. Their purpose was to review and improve patient care at the patient/nurse/physician interface. This would represent 15.4% of the positive responders to the joint practice committee question or 3.5% of all of the institutions responding.

The survey also attempted to determine if nurses were functioning in expanded roles in the hospitals. Twenty-six hospitals answered that such expanded roles did exist. Five of these indicated that the hospital employed nurses for special functions such as an emergency room coordinator, infection control nurse, respiratory therapist and home health coordinator. Only one in this group indicated that there was an affiliate staff status for this classification of personnel. (Table 1)

Six respondents indicated that they employed clinical specialists—all were hospital employees and had no staff status.

We eliminated persons designated by respondents as functioning in expanded roles who appeared, rather, to be functioning in designated ways (*i.e.*, infection control nurse). Personnel who, at least by title, seemed to truly function in expanded roles, included six clinical specialists, 14 nurse practitioners and four nurse-midwives, for a total of 24 individuals identified to be functioning in this broader scope.

Eleven individuals in these expanded roles were employed by physicians rather than hospitals. While most had no apparent staff status, nearly half did have staff status as affiliate staff members and as extensions of individual or department physician privileges.

Four indicated that nurse practitioners were employed by the hospital without staff status. These were designated as pediatric and/or adult nurse practitioner and pediatric nurse associates.

Nine respondents reported physician employed nurse practitioners functioning in their hospitals. Four of these had no staff status, while three had staff status as affiliate and two as an extension of physician privileges.

Four hospitals indicated that nurse midwives functioned within their institutions. None had

Table 1

**Hospital Personnel Reported
As Functioning in Expanded Roles**

Hospital Employed without staff status (14)
6 clinical specialists
4 nurse practitioners
3 nurse midwives
1 nurse anesthetist ("allied staff")

Physician Employed, functioning in-hospital without affiliate staff status (7)
6 nurse practitioners
1 nurse midwife

Physician Employed with affiliate staff status (7)
3 nurse practitioners
2 surgical assistants
1 health care assistant
1 liaison nurse

Hospital Employed with affiliate staff status (1)
1 nurse practitioner

No employer designated (1)
1 physician assistant

TOTAL IN-HOSPITAL EXPANDED ROLE PERSONNEL REPORTED: 30

staff status; three were hospital employed, and one physician employed.

Two surgical assistants were indicated by the respondents, both physician employed and with affiliate staff status. One hospital included a nurse anesthetist as an expanded role, hospital employed and on the "allied staff."

Other roles difficult to classify included a physician-employed health care assistant and physician-employed liaison nurse. Both had affiliate staff membership. There was one P.A. indicated without any definition as to employer or staff status.

One rather unique classification was that of a nurse practitioner employed by the department of medicine with staff status as an affiliate of the department of medicine. This is interesting in that she apparently works for the entire department and is seen as an extension of that department's privileges.

A total of 10 non-hospital personnel were reported as perceived in joint practice arrangements (Table 2). This group, comprising the remainder of expanded role personnel reported in the survey, included nurse practitioners, physician assistants and two persons reported as fulfilling an expanded role without further elaboration.

Responses concerning knowledge of joint practice arrangements in the community were: yes—14; no—72; unsure—14; no answer—11. Most were nurse practitioners in offices (eight), two

Table 2

**Non-Hospital Personnel Reported
As Functioning in Expanded Roles**

Nurse Practitioners (5)

4 in private joint practice arrangements
1 working with 9 physicians in an HMO

Physician's Assistants (3)

3 working within physicians' private office practice

Other (2)

No further designation

TOTAL NON-HOSPITAL EXPANDED ROLE PERSONNEL REPORTED: 10

P.A.s were listed. It is interesting to note that hospitals responding negatively to having a joint practice structure identified more community joint practice arrangements than did the others.

Nine instances of RN independent practice were identified, none of whom were recognized as being associated with in-patient care. Again, the no i-joint practice hospitals identified most of these RNs (eight of the nine).

Conclusion

There has been a significant amount of discussion over a considerable length of time in regard to the expanded scope of nursing, the development of health care team, and the implementation of joint practice committees and arrangements. A national commission on joint practice has been actively functioning to further develop joint practice, and Illinois has had an active joint practice committee for four to five years. Educational efforts have been underway in nursing to provide nurses with increasing skills to meet the additional needs required by a larger scope within nursing. In spite of this effort and activity, it would seem that the impact of joint practice on the hospitals in Illinois has been minimal. Twenty-three percent of the hospitals included in the survey recognize some type of multi-disciplinary approach to patient care but less than 4% had anything approaching a true joint practice committee.

No hospital described how a nurse functioning in an expanded role obtains staff privileges.

This survey would further suggest that the expanded role may be impacting more on the non-institutional practice of medicine since a significant proportion of the hospitals reporting that

expanded roles existed and were being utilized within their walls, recognized that the joint practice arrangement was between the practicing physician and the nurse practitioner. This indeed may be the place where the joint practice arrangement with the nurse in expanded role will be most viable.

The degree of interest expressed in answer to the query of how the Illinois Joint Practice Committee could be helpful, suggests the need for additional information, education and attitudinal adjustment that might allow enlargement of the health care team and inclusion of the nurse in her expanded role in that team. Some suggested informational and educational materials to be sent to active staff leaders, to administration, and to nursing heads with the appropriate guidelines, protocols, and detailed procedures, so that the function of joint practice committees could be discussed and considered with results or outcomes reported from other areas. This educational effort represents the challenge that was truly the product of this survey. Approximately 1/3 of the respondents said they would be or might be interested in a program concerning joint practice. ◀

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Illinois Medical Practice Act Amended

Physician Advertising Focus of New Law

On January 1, 1980, Senate Bill 674, as amendatorily vetoed by Governor James R. Thompson, becomes law. The text of that bill, now Public Act 81-1136, is reprinted below as a service to the membership. Changes are effected in the Illinois Medical Practice Act, Sections 16 and 16.01, which deal with advertising by physicians. The new items are included in Section 16.01. Section 16 was amended by deleting disciplinary grounds based on advertising. Items 4, 9, and 12 cover violation of the advertising section.

The January IMJ will report on actions by the ISMS House of Delegates at the November 10-11 Interim Session, regarding ISMS policies on advertising by physicians.

AN ACT to amend Sections 16 and 16.01 of the "Medical Practice Act", approved June 30, 1923, as amended.

WHEREAS, The intent of the legislature is to provide uniform standards for the advertising of professional services by persons licensed under the Medical Practice Act; and

WHEREAS, The State has a very real and compelling interest in restricting the advertising of health care services to that which is informative and helpful to the potential consumer in making an intelligent decision; therefore

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 16 and 16.01 of the "Medical Practice Act," approved June 30, 1923, as amended, are amended to read as follows:
(Ch. 111, par. 4433)

Sec. 16. The Department may revoke, suspend,

place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than.
 - (a) a facility licensed pursuant to the "Am-

bulatory Surgical Treatment Center Act" as heretofore or hereafter amended;

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;

3. Gross or repeated malpractice resulting in serious injury or death of a patient;

4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

6. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination

therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefore;

10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

11. Revocation or suspension of a medical license in a sister state;

12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

13. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act," as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

14. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.

15. Abandonment of a patient.

16. The use or prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.

17. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.

18. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.

19. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.

20. Willfully making or filing false records or reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code.

21. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.

22. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.

23. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code.

24. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.

25. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, or certificate on any of the foregoing grounds, except the ground numbered 8 (fraudulent grounds excepted) must be

commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, or certificate was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license, or certificate under this Act is a person in need of mental treatment operates as a suspension of that license, or certificate. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

(Ch. 111, par. 4434)

Sec. 16.01. Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(1) Publication of the person's name, title, office hours, address and telephone number;

(2) Information pertaining to his areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered which such information shall include notification that fees may be adjusted due to complications or unforeseen circumstances;

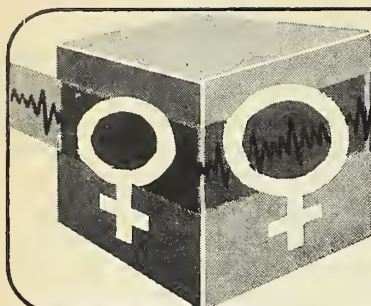
(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff;

(6) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition. ◀



pulse...

of the ISMS auxiliary

Happy Holidays From The Hoovers

BY MRS. R. SAMUEL HOOVER, PRESIDENT, ISMSA



A subject that has generated much interest and controversy this year in the auxiliary is that of medical marriages. Are doctors wives/spouses happy? If not, why not? Can the Auxiliary do anything to improve the general situation without becoming involved in individual marital problems? Are we doing a good job as doctor's wives? What makes a good doctor's wife?

These and the underlying question—are physician's marriages really unhappy?—dominated the conversation at a June taping of the popular Phil Donahue Show. Donahue devoted his entire pro-

gram to a discussion of what it's like to be a doctor's wife, and asked the AMA Auxiliary to provide the audience of 200 physician's spouses. The show was prompted by the media interest provoked by a recent survey of 1000 (only) doctor's wives taken by the commercial magazine, *Medical/Mrs.* The survey, taken on the East Coast, found that most of those who answered were unhappy.

Donahue intended to give the medical wives a chance to air their grievances. What he got was a spirited defense of physicians, medicine, and

medical marriages. The Auxiliary members "came through" as a peer support group *par excellence*—one any profession would be proud to have. Some genuine concerns were raised about doctors and medical marriages—the long erratic hours, the time away from growing children and spouses in need of companionship, the tendency of physicians to talk only to other physicians and to talk patronizingly or to ignore others, the tension between doctors and nurses over who should do what in the hospital, the extra-ordinary status the doctor and doctor's family hold in our society and how this can interfere with family privacy as well as family activities.

Star of the show was Pat Walker, panelist, representing the Auxiliary. Mrs. Walker, of Springfield, Missouri, noted that "Frankly, I'm getting a little tired of this emphasis on failing medical marriages. The stresses and strains on a family are same no matter what your occupation. I've been married to a doctor for 27 years, and many of the problems we've worked out would have occurred no matter what his occupation. Things are better now, as far as a doctor spending time with his family, because with modern medicine, the physician can control things a lot more. I think the advent of group practice and the beeper emancipated a lot of wives."

Mrs. Ben Johnson, President of the AMA Auxiliary, noted in a recent article that "I think many of these disappointed doctor's wives must not be very secure in themselves. If women marry a doctor expecting instant money and glamour, they're in for a shock. It's meant to be a life of service. That's the real reward."

Also on the Donahue Show, Diane Hinderliter, Illinois Auxiliary's First Vice President contributed, "Every marriage is unique. We are, after all, all individuals and responsible for our own happiness." This seems to be the crux of the matter—doctor's wives, like any other wives, must develop their own interests and emotional support systems in their communities. Mrs. Johnson comments, "Sure he's a busy man. But I am busy too. I've always had my books and civic activities—and the children, of course." Besides, the human being is infinitely flexible—seemingly we can adjust even to very difficult situations. And surely, we would want to "adjust" to our individual husbands' desires and personalities—after all, we married them.

As a teenager, I had proclaimed, "I'll never marry a doctor,"—that was before I had met my husband, of course. I had to eat my words in 1955 when we were married. Then two, then

three, four, five and six of us went through medical school, internship, service, post graduate degree and finally residency during the next ten years. I don't think there were many crises or situations that we didn't solve together. Thirteen moves in ten years, for example—like many doctor's wives, I became an expert packer and mover. I had to. Like every other housewife I became chief cook, bottle washer, chauffeur, gardener, laundress, up and downstairs maid, and governess. The fact that my husband was in medicine made no difference at all—other than the fact that I felt a certain obligation to do volunteer work, but I probably would have done that anyway. I also took up golf—supposedly for a little "togetherness," but soon became hooked, myself.

Holidays were great fun too; one learns to *manage*. The third New Year's Eve in a row on call was a little difficult to take, but nothing like that of a friend of ours who changed from dinner jacket to scrub suit three times one New Year's Eve — to have the dubious distinction of delivering the last two babies of one year and the first of the new! And the holidays meant trouble—more traffic accidents, for example—something I didn't really think about before marrying a physician. And what to do when a friend comes to the door asking for medical advice or medication? Unfortunately, we have trouble finding a band aid at our house, and might possibly have aspirin (if I remembered to buy any) to the amazement of some of our friends. So, I couldn't be of much help.

It was exciting to set up practice, too, and adjust to a new community, to find new friends. Medicine really is a bit of a hard mistress, demanding of her physicians and their families, but exciting and changing constantly—a challenge for all of us. What makes a good doctor's wife? Someone has said, nerves of steel, a nursing background, and an independent income. Not many women I know have those specific qualifications. I think that perhaps strength, and endurance, and independence, plus a respect for the profession, and a sense of humor—on call at all hours—those are real assets!"

So, almost twenty five years later, I look back and think that it has been such a short time, yet so long. So many shared experiences and discoveries made together have occurred—and so many crises over the dam—I wonder what the next twenty five will bring? God Bless you all and Happy Holidays!

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ANNA: Internist with special interest in Cardiology. Good EKG volume, exclusive interpretation privilege. New 4 bed Special Care Unit. Some general practice required. Guaranteed Salary. Located within 35 minutes of Southern Illinois University Medical School Carbondale, Cape Girardeau, Mo. and Paducah, Ky. Contact: E. A. Helfrich, Adm. or Ken Simpson, Asst. Adm. Union County Hospital, 517 N. Main St., Anna, 62906. Telephone Collect: 618-833-5155 (12)

AURORA: Population 80,000. Opening in 40 man multi-specialty group—located 45 miles from downtown Chicago. Complete office and ancillary services available. Starting salary and benefits with stockholder status, two years. Contact Leonard E. Snyder, 1870 W. Galena Blvd., Aurora, 60506. (312) 859-6700. (3)

CHICAGO AREA SUBURBS: Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12)

FAIRBURY: Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (12)

FLORA: Family Practice Physician is needed in Flora, Ill., a stable community in Clay County in south central Illinois. Financing available with a guaranteed income. We have good schools, roads, hospital and neighbors. Contact J. Luff, Administrator, Clay County Hospital Flora, Ill. 62839 (618-662-2131). (1)

FREEPORT: Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business

Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

GALESBURG: Population 38,000. Western Illinois, diversified manufacturing and agri-business—stable employment. Excellent cultural, recreational opportunities, home of Knox and Carl Sandburg Colleges. Practice opportunities in various specialties. Financial assistance available. CONTACT: David D. Fleming, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401, 309/343-8131. (1)

GALESBURG: Opening for full time emergency physician in modern trauma center hospital. 12,000 annual visits. Excellent specialty backup. Good salary and flexible schedule. Very nice community, population 36,000. Contact: Fares N. Aris, M.D., St. Mary's Hospital, 3333 N. Seminary St., Galesburg, 61401. (309) 344-2919. (3)

GARDNER: Population 2500 (surrounding area 20,000). Opportunity for physician seeking family practice. Very modern medical building available, only one dentist in building (previous physician deceased in May, 79). Very pleasant rural/industrial community only 30 miles from Joliet. Will assist with financing. CONTACT: Chuck Chladek, Depot St., Gardner 60424. Phone (815) 237-2366 or (815) 584-1152. (1)

GENESEO: Family Practice/Pediatrician/Internist/Orthopedic acutely needed. Ultra modern hospital. Walk in office, complete facilities. Population 7,000, trade area 29,000. 150 miles from Chicago, Interstate 80. 25 miles from Quad-Cities. Nine physicians at present. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo, 61254 Ph. AC 309-944-2530. (3)

GENOA: Population 3500 (surrounding area 15,000). Excellent professional and cultural opportunity for physician seeking independent family practice. Pleasant family community. Located between Chicago, DeKalb, and Rockford. 15 miles from Northern Illinois University. Contact: Irving M. Bush, M.D., 1 Chapman Road, Burlington, 60109. Phone 312-683-2066 or 312-683-2081. (4)

GREENUP: Family Practitioner, present physician retiring. Office building, complete with pharmacy and X-ray unit for sale. Factories close, financial assistance available. Good community and practice. Located 190 miles south of Chicago, 20 to 25 miles from Eastern Illinois University and Lakeland Jr. College. Contact: Nicholas J. Beck, M.D., 300 N. Mill St., Greenup, 62428. Phone: 217-923-3311 or 217-923-5134. (1)

KEOKUK, IA: Population 15,000. Opening for family and specialty physicians. Hospital currently undergoing 9.5 million dollar expansion project. Twenty-two physicians at present. Sixty miles from Burlington, IA. Complete office facilities. Financial assistance available. Join our progressive community situated on the banks of the beautiful Mississippi. Contact: Dr. Lynn Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, IA 52632, AC 319-524-7150. (1)

MACOMB: G.P./F.P. 12 month contract, Illinois License Practice University Health Service outpatient clinic. No OB or surg. Fringes include hospitalization, paid vacation, retirement, etc. Approx. 11,000 students, city 23,000. Competitive negotiable income. EOE/AA. C.E. Hughes, M.D., Director, Beu Health Center, Western Illinois University, Macomb, 61455. (309) 833-2734. (3)

MOUNT CARMEL: Growing southern Illinois community of 10,000 located 40 miles north of Evansville, Indiana on the Wabash River. Acute care hospital offering a wide range of services located in the community. Near universities and colleges. Guaranteed income and other financial assistance offered. Contact: William E. Lee, 1418 College Drive, Mount Carmel 62863 (618-262-4121). (1)

MT. ZION: Population 4300. A fast growing modern community. Our present Doctor moved to northern part of state. There are two (2) major hospitals in De-

catur, eight (8) miles from Mt. Zion. Office facilities available. Unlimited possibilities. CONTACT: Woodrow Gosnell, 1115 N. State Hwy., Mt. Zion, 62549, AC 217-864-2171. (1)

OBLONG: Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

VANDALIA: Population 5,500. Progressive town in rural Fayette County urgently needs family practice physicians, also internist and pediatrician. Hospital serves county population of 25,000. Seven physicians at present. Sixty miles from St. Louis on I-70. Office facilities available, also financial assistance. CONTACT: John Leckrone, Administrator, Fayette County Hospital, Vandalia. Phone collect 618/283-1231. (1)

WHITE HALL & ROODHOUSE: Combined population of 6000 (2 miles apart), 3 physicians. 16,000 persons. 30 bed hospital, built 1978. Complete primary care diagnostic support. Group or solo. Hospital assistance. One hour from major medical complexes and medical schools. Family communities w/sound education and abundant recreation. Contact Larry Bear, White Hall Hospital, 407 N. Main, White Hall 62092. (217-374-2121). (1)

LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,
ASSISTANCE
& DETAILS CONTACT:

Administrators:

PARKER A. SAUNDERS & COMPANY
ESTABLISHED 1901
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THE GROUP DISABILITY PLAN ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE BASIC MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$150.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

EXCESS MAJOR MEDICAL PLAN ● Provides up to \$500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a \$15,000, \$20,000 and \$25,000 deductible. Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue
Skokie, Illinois 60077
Phone: 312-679-1000



Recap

Recent Educational Seminars By AAMA, Illinois Society

This month's column is intended to acquaint Illinois State Medical Society members with the calibre of past programs and those planned for the future. We hope that this information will encourage ISMS members to invest in the future of their medical assistants and their practice.

On October 28, 1979, an educational seminar held in Decatur featured:

- Mammography and X-ray—"Tumor Findings"
- Microscopic Examination—"Tissue Pathology Procedures"
- EMT Training—"Who Should Have It; Why We Should Have It"

On November 11, 1979, subjects covered in a Flossmor, Illinois, AAMA Illinois Workshop included:

- "How To Manage Your Hard Earned Dollars"
- "Women and the Law—Taking Off The Blindfold"
- "The Insight About People's Dependency on Food Choices and Their Effect On Lives and Work"

On December 5, 1979, at the University of Chicago Center for Continuing Education, the program included:

- Diagnostic Testing in the Office
- Demonstration of Laboratory Instrumentation
- EKG Technology Update

team, a proficient medical assistant must keep up to date and in tune with the changing times. Her knowledge of new procedures and advances in medicine should keep pace with yours.

Members of AAMA participate in organized educational activities. These include planned meetings, study groups and tours of hospitals, pharmaceutical companies and other medically related facilities. They also attend lectures, continuing education programs and workshops.

Members have learned how an exchange of professional ideas can broaden the scope and effectiveness of medical assisting. Your medical assistant will make new friends and enjoy an affiliation with others in her field when conferring on mutual problems.

Encourage your medical assistant (if she is not already a member) and encourage your colleagues to encourage their medical assistants to take the giant step toward self-improvement by becoming a member of American Association of Medical Assistants—Illinois Society. It will increase her professionalism and improve her job performance.

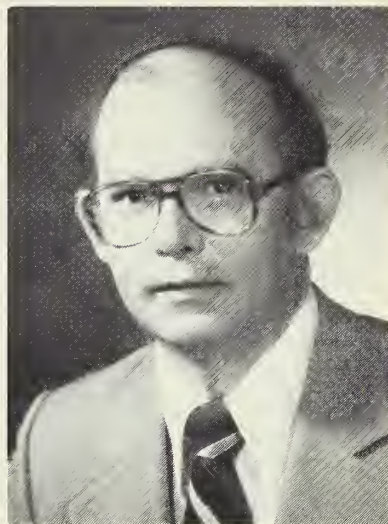
For membership information contact Cissy A. Moran, CMA, president, 1413 Midland Manor, Joliet, IL 60436 or Luella V. Mitchell, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

Keeping In Step

To be an effective member of the health care

President's Page

There is no security on this earth; there is only opportunity.
Gen. Douglas MacArthur



The Importance Of Perspective

It is traditional to approach a new year by making a commitment to address our problems with renewed vigor. Too often, that resolve escalates into compulsiveness and distorts our perspective. We become so concerned with conquering the negative that we blindly ignore opportunities for innovation.

An objective analysis of many so-called problems may reveal that they actually are opportunities, obscured only by our negativism. To flourish, medicine must view the new year as a period of opportunity . . . and exercise creativity in providing patient care and guiding development of the new health care system. Simply stated, we must exercise leadership.

History documents that medicine always has been committed to progress. That commitment is our most valued asset and a characteristic which spawns opportunity. The external forces which threaten to constrain medicine's creativity cannot be allowed to weld our focus to the negative.

Ill-advised proposals for changes in the health care system can be transformed into plans for improvement. By doing that, we seize opportunity and enhance our image as innovators. ◀

A handwritten signature in dark ink, reading "P. John Seward, M.D.". The signature is written in a cursive, flowing style.

P. John Seward, M.D., President

Washington Ne

TUESDAY, FEBRUARY 5, 1979

WASHINGTON NEWS GAZETTE

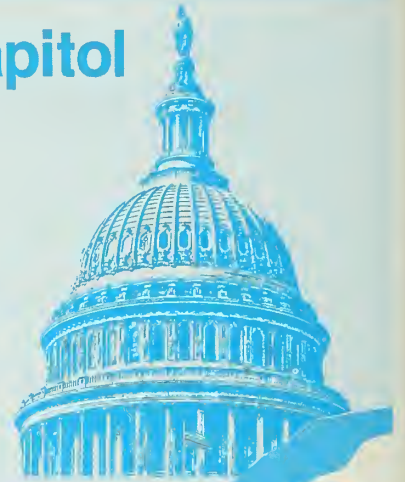
Illinois Physicians Storm U.S. Capitol

ISMS WIRE SERVICE

Over 200 Illinois physicians and their spouses stormed the Capitol yesterday in a strong demonstration of interest in the federal regulatory process. Featured in their program were presentations on key current federal legislation.

The physicians plan to be in

Washington to continue their assault until Wednesday, February 6, 1979. Agenda items include remarks by congressional staff members, an outline of the Federal Trade Commission's views on professional advertising, a prospectus on national health insurance, special Washington bus tours, performances at the Kennedy Center.



Do you want to be part of the news next February?

**If so, then make plans now to attend
the 1980 ISMS Washington Roundup!**

SIGN ME UP! I want to attend the 1980 Washington Roundup.

My spouse _____ children _____ will also be attending.

Name _____

Address _____

City _____ Zip Code _____

Phone _____

Return this form to: Governmental Affairs Division
Illinois State Medical Society
55 E. Monroe, Suite 3510
Chicago, Illinois 60603

ISMS STAFF will forward all necessary
information upon receipt of this coupon.

Doctor's News

LICENSE RENEWAL REMINDER—All Illinois medical licenses will be subject to renewal by the Illinois Department of Registration and Education as of July 1, 1980. Forms for license renewal will be mailed next spring.

Illinois law requires that continuing medical education (CME) credit be earned during a pre-license renewal period. Statutes stipulate that at least 50 hours of Category 1 and an additional 50 hours of Category 2 credit be earned by each physician during the two year period April 1, 1978 through March 31, 1980. Of the 50 hours Category 1 credit, a minimum 20 must be part of an approved, formal educational program as specified in the Act. The balance may fall into the realm of approved teaching or medical care audit activities.

NUTRITION CONFERENCE ANNOUNCED—The Fourth Clinical Congress of the American Society for Parenteral and Enteral Nutrition is scheduled for January 30-February 2, at the Chicago Palmer House. ASPEN is a multi-disciplinary association of physicians and allied health personnel engaged in contemporary clinical nutrition. Registration for physicians who are not members of ASPEN is \$175 through January 11, 1980. A \$25 late registration fee will be assessed after that time. For further information about the program, write Karen L. Kight, Meeting Manager, American Society for Parenteral and Enteral Nutrition, Inc., 6110 Executive Boulevard, Suite 810, Rockville, MD 20852.

MEDICAL REVIEW PROGRAMS ANNOUNCED—The Center for Health Sciences at Oakland University in Rochester, Michigan, has announced that their next Medical Review Program is scheduled for March 12 through June 7, 1980. The program is designed for persons preparing to take the FLEX, ECFMG and VQE examinations. Students are registered as full-time graduate students at the university and receive 16 academic credits for the course, which provides an intensive 12-week review of the basic and clinical sciences, as well as patient management problems, with an emphasis on clinical relevance. Tuition and fees at present are \$638.50. Classes are held 3:30-10:00 p.m., Monday through Friday and 9:00-4:00 p.m. on Saturday. Further information may be obtained by writing: Medical Review Program, Center for Health Sciences, Oakland University, Rochester, MI 48063. Telephone: (313) 377-3563.

PANDA VISITS THE DOCTOR—is the title of a booklet available to teach children four to eleven years of age what to expect on a visit to the physician's office. The coloring book takes a mythical character through a visit to the doctor, introducing equipment and procedures of a typical office examination. Other booklets in the series include "Panda at the Hospital," and "Panda Goes to Surgery." They are available from Panda Programs, 1872 W. Lotus Place, Brea CA 92621, at a cost of \$2.50 each.

USEFUL PAMPHLETS AVAILABLE—The Chicago Bar Association has published a series of pamphlets of potential interest to Illinois physicians. "Some Helpful Information for Illinois Doctors," discusses physician responsibility in the event of subpoena and deposition and other pertinent information about some Illinois laws. Other pamphlets include, "What Every Parent Should Know About Adoption," "What About Your Will?" and "Know Your Courts." The pamphlets, which are intended only for information rather than legal advice, may be obtained by writing the Chicago Bar Association, 29 S. LaSalle Street, Chicago 60603. Telephone (312) 782-7348.

CDC REPORTS—The U.S. Department of Health, Education and Welfare Center for Disease Control recently reported that the reported number of gonorrhea cases in 1979 appear to have decreased slightly from last year's figures. Between 1965 and 1975, reported cases of gonorrhea in the U.S. tripled. In 1979, however, the projected number of cases, 1,010,000, represents only a 1% increase over 1975 figures. It is anticipated that reported cases among men will be 594,000 (.6% decrease from 1978) and 416,000 among women (about equal to the number reported in 1978). In their report, CDC authorities note that case reports on men are considered more accurate reflections of actual incidence because gonorrhea in males more often causes acute symptomatic disease. This data is more fully documented in the *CDC Morbidity and Mortality Weekly Report* of November 16, 1979.

JAIL HEALTH PROGRAM UPDATE—The Williamson County Jail was recently selected to participate in the ISMS-administered Illinois Jail Health Program, aimed at upgrading health services in jails in accordance with national jail health standards developed by the American Medical Association. Other county jails currently participating in the program include those in Champaign, Cook, Jackson, Lake Macoupin, Madison, Marion, McHenry, Tazewell and Vermilion Counties. Kane County Adult Correction Facility in Geneva has achieved AMA accreditation under the program. An in-depth report on the Jail Health Program will be featured in an upcoming issue of *IMJ*.

PHYSICIANS IN THE NEWS—**Boyd McCracken, M.D.**, Greenville, was recently appointed to the AMA Committee on CME Accreditation. Dr. McCracken, a member of the ISMS House of Delegates representing Bond County, is an ISMS alternate delegate to the AMA . . . **J. Robert Buchanan, M.D.**, Chicago, was recently named chairman of the Illinois Hospital Association Board of Trustees. Dr. Buchanan is president of the Michael Reese Hospital and Medical Center, and has served on the Illinois State Cost Containment Committee . . . **Leon Love, M.D.**, Chicago, recently received the Chicago Medical School Distinguished Alumni Award for his internationally-renowned work in radiology. Dr. Love also serves as *IMJ* Contributing Editor for the monthly "Viewbox."

William J. Kane, M.D., Chicago, was recently installed as president of the Scoliosis Research Society . . . **John T. Gregorio, M.D.**, River Forest, has been confirmed by the Illinois Senate Executive Committee to serve as a member of the Illinois Department of Registration and Education Medical Disciplinary Board.

Chicago physician **Sandra J. Olson, M.D.**, has been named to serve on the AMA Ad Hoc Committee on Women Physicians in Organized Medicine . . . **Morris T. Friedell, M.D.**, was recently honored at a gala celebration of his twenty years' service in governing Jackson Park Hospital. Dr. Friedell, immediate past president of the Chicago Medical Society, is a member of the ISMS Board of Trustees and an alternate delegate to the American Medical Association.

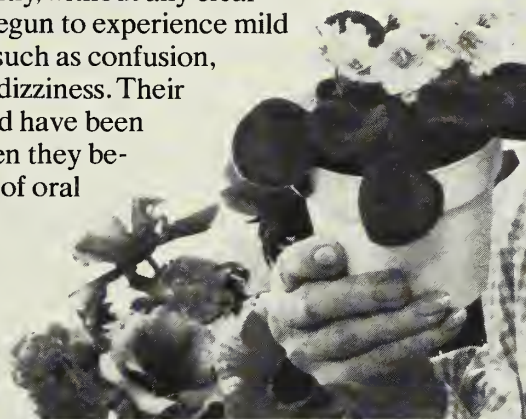
E. Stephen Kurtides, M.D., Chicago, associate professor of clinical medicine at Northwestern University Medical School, has been named chairman of the department of medicine for the Evanston Hospital Corporation . . . Four Illinois physicians have been admitted as fellows to the American College of Cardiology. They are: **Maria H. Balkoura, M.D.**, Chicago, **Robert A. Bielinski, M.D.**, Skokie, **Behrooz Eshaghy, M.D.**, Broadview and **Ralph E. Otto, M.D.**, Evanston.

Gerald S. Gotterer, M.D., Ph.D., has been appointed associate dean of Rush Medical College in Chicago. Dr. Gotterer, it was announced, will be responsible for admissions, academic counseling, curriculum development and related undergraduate medical student programs. He will also serve on the Rush faculty as associate professor in the Department of Biochemistry, and assistant professor in the department of internal medicine. . . **S. P. Kaiz, M.D.**, recently commemorated 45 years of service and dedication at a ceremony at which Abbott Laboratories presented him their Golden Hour Clock.

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500.

Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg, packages of 100 and 1000.

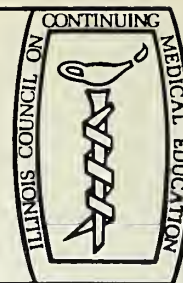
Before prescribing, see package insert for full product information.

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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

JANUARY

Alcoholism

Current Concept of Alcoholism

For: GP's, fulltime specialty. Lecture, Jan. 9, 1:30 p.m., Chicago. Speaker: David Lichtenstein, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Culver Hall 405, Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Anesthesia

Anesthesia Update 1980 Clinical Management for the Anesthesiologist

For: Primary Care. Course, Jan. 26, 8:00 a.m., Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan, Indianapolis 46223. Fee: \$50. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: John Roscoe. Phone: 317/264-8353.

Audiology

How to Assess Hearing in Infants and Toddlers for the Primary Care Physician

For: Primary Care. Course, Jan. 19, 8:00 a.m., Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan, Indianapolis 46223. Fee: \$50. Reg. limit: none. Credit: AMA Category 1, 7 hours; AAFP Prescribed, 7 hours. Contact: John Roscoe. Phone: 317/264-8353.

Family Medicine

Sports Medicine—Physical and Psychological Aspects

For: MD's. Lecture, Jan. 16, 1:00 p.m., Holiday Inn, Glen Ellyn. Speaker: Richard Dominguez, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. Credit: AMA Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Widmer.

Family Medicine

10th Annual Winter Refresher Course for Family Physicians

For: FP's. Course, Jan. 16-18, Pfister Hotel, Milwaukee, WI. Sponsor: Dept. of Family Practice, The Medical College of WI, Seton Tower, 2315 North Lake Drive, Milwaukee WI 53211. Co-sponsors: S.E. Chapter of the Wisconsin Academy of Family Physicians. Fee: \$160. Reg. limit: 225. Credit: AMA Category 1, 20 hours; AAFP Prescribed, 20 hours. Contact: Susanna Rechlit. Phone: 414/291-0813.

Medicine

Hepatobiliary Disorders

For: MD's. Symposium, Jan. 17, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Fee: \$30. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Lake County Medical/Surgical Seminar

For: MD's, DO's, RN's. Symposium, Jan. 30, Waukegan. Sponsor: St. Therese Hospital, 2615 Washington St., Waukegan, IL 60085. Reg. deadline: 1/28. Fee: \$3.00. Reg. limit: none. Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours; AOA, 5 hours. Contact: R. M. Adelman, MD. Phone: 312/688-6461.

Medicine

Infectious Diseases

For: MD's. Symposium, Jan. 31, 1:00 p.m., Carlinville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Fee: \$25. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, Jan. 16, 1:00 p.m., Forest Park. Speaker: Paul Wender, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Rehabilitation Medicine/ Psychology of Disability

"Why Me, God?!" Faith & Disability

For: MD's. Course, Jan. 23, 8:30 a.m., Chicago. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior, Chicago 60611. Fee: \$30. Reg. limit: 100. Credit: AMA Category 1, 6 hours. Contact: Don Olson. Phone: 312/649-6179.

Surgery

Specialty Review in General Surgery, Part II

For: Surgeons. Lecture, Jan. 14-25, Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$500. Reg. limit: 400. Credit: AMA Category 1, 99 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

FEBRUARY

Cardiology

Clinical Electrocardiography

For: Primary Care. Course, Feb. 13-14, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan, Indianapolis 46223. Fee: \$85. Reg. limit: none. Credit: AMA Category 1, 14 hours; AAFP Prescribed, 14 hours. Contact: John Roscoe. Phone: 317/264-8353.

Family Therapy

Family Systems Assessment (Introductory Course)

For: MD's, therapists. Workshop, Feb. 4-8, Chicago. Speaker: Miriam Reitz, ACSW. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$185. Reg. limit: 24. Credit: AMA Category 1. Contact: Laurie Anderson. Phone: 312/649-7285.

Family Therapy

Strategies and Techniques (Intermediate Course)

For: MD's, therapists. Workshop, Feb. 11-15, Chicago. Speaker: Robert Mark, PhD. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$185. Reg. limit: 24. Credit: AMA Category 1. Contact: Laurie Anderson. Phone: 312/649-7285.

Family Therapy

Use of Self in Family Therapy (Advanced Course)

For: MD's, therapists. Workshop, Feb. 18-22, Chicago. Speaker: Robert Rutledge, ACSW. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago 60611. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$185. Reg. limit: 20. Credit: AMA Category 1. Contact: Laurie Anderson. Phone: 312/649-7285.

Gastroenterology

Old Problems and New Trends in Gastroenterology

For: FP's. Symposium, Feb. 20, 8:00 a.m., Waukegan. Sponsor: Victory Memorial Hospital, 1324 N. Sheridan Rd., Waukegan 60085. Fee: \$10. Reg. limit: 110. Credit: AMA Category 1, 5 hours; AAFP Elective, 5 hours. Contact: Frank Magliery. Phone: 312/688-4001.

Medicine

Emergency Radiology

For: MD's. Symposium, Feb. 13, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Allergy

For: MD's. Symposium, Feb. 21, 1:00 p.m., Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Office Counseling—Practical Aspects

For: MD's. Symposium, Feb. 13, 8:00 a.m., Belleville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

PANAMA CANAL CRUISE

May 17-31, 1980

"Non Invasive Diagnosis of Peripheral Vascular Disease"

Sponsor: SIU School of Medicine, P. O. Box 3926, Springfield 62708. Speakers: Robert Barnes, MD, FACS; David Sumner, MD, FACS. Fee: \$500. Credit: AAFP Prescribed, 72 hours; AMA Category 1, 72 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Sixth Annual Postgraduate Course on Internal Medicine

For: MD's. Symposium, Feb. 8-9, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 10 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Fallaw-Up Immunology

For: MD's. Symposium, Feb. 5, 7:00 p.m., Vandalia. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Sexuality

For: MD's. Symposium, Feb. 23, 8:00 a.m., Benton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Obstetrics

Teenage Pregnancy

For: GP's, Obstetricians. Lecture, Feb. 13, 1:30 p.m., Chicago. Speaker: Atef Moawad, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

MARCH

Basic Sciences/Physiology

Fifth Annual Meeting of the American Society of Andrology

For: OB/GYN, Internists, Clinicians. Symposium, March 11-14, Palmer House, Chicago. Sponsor: U of I at the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. limit: \$125. Fee: \$125. Credit: AMA Category 1, 6 hours. Contact: Sue Korienek. Phone: 312/996-8025.

Chest Diseases

Respiratory Failure

For: GP's, Fulltime Specialty. Lecture, March 12, 1:30 p.m., Chicago. Speaker: Charles Rice, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

Family Medicine

Annual Meeting/Scientific Assembly

For: FP's. Seminar/workshop, March 9-15, Sheraton Twin Towers Hotel, Orlando, FL. Sponsor: American Society of Contemporary Medicine & Surgery, 6 N. Michigan, Suite 1110, Chicago 60602. Fee: \$250, members; \$325 non-members. Reg. limit: none. Credit: AMA Category 1, 40 hours; AAFP Elective, 25 hours. Contact: John Bellows, MD. Phone: 312/236-4673.

Family Therapy

Creative Problem-Solving for Professionals and Administrators

For: MD's, therapists. Workshop, March 3-7, 9:30 a.m., Chicago. Sponsor: Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago 60611. Cosponsors: Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. Fee: \$275. Reg. limit: 50. Credit: AMA Category 1. Contact: Laurie Anderson. Phone: 312/649-7285.

Medical/Legal

For: MD's. Symposium, March 6, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$30. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Medicine

Cardiovascular

For: MD's. Symposium, March 12, 1:00 p.m., Chester. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Immunology

For: MD's. Symposium, March 20, 1:00 p.m., Pittsfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Hand Symposium

For: MD's. Symposium, March 21, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 8 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Rheumatology

For: MD's. Symposium, March 22, 1:00 p.m., Lawrenceville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Medicine

Respiratory Disease

For: MD's. Symposium, March 26, 6:00 p.m., Granite City. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

Pediatrics

Dowstate Illinois Pediatric Society Meeting

For: MD's. Symposium, March 29-30, Springfield. Sponsor: Dowstate Illinois Pediatric Society, 320 E. Armstrong, Peoria 61603. Cosponsor: SIU School of Medicine. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 7 hours. Contact: Thomas Smith. Phone: 309/672-6341.

Neurology/Neurosurgery

Current Concepts in Cerebrovascular Surgery

For: MD's. Symposium, March 27-28, St. Louis, MO. Sponsor: Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. Fee: \$175. Reg. limit: 150. Credit: AMA Category 1, 16 hours; AOA, 16 hours; AAFP Prescribed, 16 hours; AANS & CNS, 16 hours. Contact: Loretta Giacomello. Phone: 314/454-3873.

Primary Care

Coronary Disease, Exercise Testing, and

Cardiac Rehabilitation

For: GP's, Internists. Lectures/workshops, March 21-23, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 13 hours; AOA, 13 hours; AAFP Elective, 13 hours. Contact: Stephen Mattingly. Phone: 800/525-8646 x 237.

Psychiatry

Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, March 19, 1:00 p.m., Forest Park. Speaker: Alexander Lowen, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

Pulmonary Medicine

Pulmonary Board Review Course

For: MD's. Course, March 31-Apr. 4, Conrad Hilton Hotel, Chicago. Speaker: Reuben Cherniack, MD. Sponsor: American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. Contact: Mary Ellen Zielinski. Phone: 312/698-2200.

Pulmonary-Pediatric

Pediatric-Pulmonary Conference

For: Pediatricians, FP's. Course, March 5-6, Indianapolis, IN. Sponsor: Indiana University School of Medicine, Div. of CME, 1100 W. Michigan, Indianapolis 46223. Cosponsor: American Lung Assn. of Indiana. Fee: \$85. Reg. limit: none. Credit: AMA Category 1, 14 hours; AAFP Prescribed, 14 hours. Contact: John Roscoe. Phone: 317/264-8353.

Rehabilitation Medicine

Contraversial Issues in Aphasia Therapy

For: Speech Pathologists, Audiologists. Course, March 7-8, Chicago. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. Fee: \$60. Reg. limit: 100. Credit: AMA Category 1, 12 hours. Contact: Don Olson. Phone: 312/649-6179.

Sports Medicine

Spats Medicine Postgraduate Course

For: MD's. Course, March 9-16, Maui, Hawaii. Sponsor: Northwestern University Medical School Center for Sports Medicine, 303 E. Chicago, 2-063, Chicago 60611. Cosponsor: Div. of Sports Medicine, North Carolina Dept. of Public Instruction. Reg. deadline: 2/1. Fee: \$250. Reg. limit: none. Credit: AMA Category 1, 25 hours. Contact: Bates Noble, MD. Phone: 312/649-7959.

Surgery-Gastroenterology

Gastrointestinal Problems of the Elderly

For: MD's. Symposium, March 7, 10:45 a.m., Oak Park. Speaker: R.J. Vacca, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery-Gastroenterology

Gallbladder Disease—A Diagnostic Guide

For: MD's. Symposium, March 14, 10:45 a.m., Oak Park. Speaker: John Howser, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery-Gastroenterology

Colonoscopic Examination—A Diagnostic Aid for Disease of the Colon

For: MD's. Symposium, March 21, 10:45 a.m., Oak Park. Speaker: D. M. Kruss, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

Surgery-Gastroenterology

Endoscopic Examination

For: MD's. Symposium, March 28, 10:45 a.m., Oak Park. Speaker: D. M. Kruss, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

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PROSPEROUS COMMUNITY needs a general practitioner to take over practice of retiring family practitioner. Will sell practice and house to new doctor. Contact A. DeMola, M.D., Colfax, IL (309) 723-2431.

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CHAIRMAN, PSYCHIATRIC DEPT.—The Ravenswood Hospital Medical Center, located at 4550 N. Winchester Avenue in Chicago, Illinois, a teaching/community 450 bed hospital, is seeking a part time chairman for the psychiatric department. The hospital is affiliated with the Abraham Lincoln School of Medicine of the University of Illinois. The individual being sought for this position must be board certified or board eligible, with demonstrated competence in his/her specialty; shall have demonstrated professional and administrative abilities; and shall possess a knowledge of current educational principles. He/she will be administratively responsible for the Department of Psychiatry and for the coordination and integration of psychiatric education programs at the medical center. The Medical Center offers a competitive salary and benefit program. Qualified applicants please submit resume in confidence, to: Chairman, Search Committee, c/o Medical Staff Office, Ravenswood Hospital Medical Center, 4550 N. Winchester, Chicago, Illinois 60640, (312) 878-4300, ext. 1550. Ravenswood is an equal opportunity employer.

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“I Quit” Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of “I Quit Smoking” clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

January 2	Highland Park Hospital	Highland Park
January 7	Resurrection Hospital	Chicago
January 8	South Suburban Hospital	Hazelcrest
January 28	Lutheran General Hospital	Park Ridge
February 4	Christ Hospital	Oak Lawn
April 14	Christ Hospital	Oak Lawn
April 28	Lutheran General Hospital	Park Ridge
June 16	Christ Hospital	Oak Lawn
July 28	Lutheran General Hospital	Park Ridge
September 15	Christ Hospital	Oak Lawn
October 27	Lutheran General Hospital	Park Ridge
November 17	Christ Hospital	Oak Lawn

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